Gloucestershire Clinical Commissioning Group Shadow Board

AGENDA

Meeting to be held at 2pm on Thursday 17th January 2013 in the Board Room, Sanger House, Brockworth, Gloucester GL3 4FE

No.	Item	Lead	Recommendation
1	Apologies for Absence	Dr Helen Miller	
2	Declarations of Interest	Dr Helen Miller	
3	Minutes of the Meeting held on Thursday 15 th November 2012	Dr Helen Miller	Approval
4	Matters Arising	Dr Helen Miller	
5	Chair's Update	Dr Helen Miller	Information
6	Members' Reports • Gloucester City • North Cotswold	Dr Helen Miller	Information
7	Commissioning for Quality Report	Jill Crook	Information
8	Performance against Commissioning Report	Mary Hutton	Information
9	QIPP Programme Update	Mary Hutton	Information
10	Annual Operating Plan	Mary Hutton	Approval
11	Any Other Business (AOB)	Dr Helen Miller	
12	Public Questions	Dr Helen Miller	
Date and time of next meeting: Thursday 21st February 2013 at 9.30am in Board Room at Sanger House			

Gloucestershire Clinical Commissioning Group (CCG)
Shadow Board

Minutes of the meeting held on Thursday 15th November 2012
in the Board Room, Sanger House, Gloucester GL3 4FE

Present:

Dr Helen Miller	HM	Chair
Dr Andy Seymour	AS	Deputy Clinical Chair
Dr Shona Arora	SA	Director of Public Health
Dr Caroline Bennett	CBe	GP - North Cotswolds Locality
Dr Charles Buckley	CBu	GP - Stroud & Berkeley Vale Locality
Jill Crook	JC	Director of Nursing
Alan Elkin	AE	Lay Member
Debra Elliott	DE	Director of Commissioning Development
Malcolm Gerald	MGe	GP
Martin Gibbs	MG	GP - Forest of Dean Locality
Dr William Haynes	WH	GP - Gloucester City Locality
Mary Hutton	MH	Director of Finance
Hein le Roux	HLR	GP - Stroud & Berkeley Vale Locality
Richard Lewis	RL	Deputy Director of Human & Corporate Resources
Liz Mearns	LM	Medical Director
Rob Rees	RR	Lay Member
Jan Stubbings	JS	Chief Executive
Dr Jeremy Welch	JW	GP - Tewkesbury Locality
Margaret Willcox	MW	Commissioning Director Adults and Director of Adult Social Services

In attendance:

Julie Clatworthy	JC	Registered Nurse
Emma Simpson	ES	Board Administrator
Mark Walkingshaw	MW	Locality Commissioning Director
Valerie Webb	VW	CCG Lay Member for Business

There were 17 members of the public present.

1 Apologies for Absence

1.1 Nuala Ring, Sarah Hughes.

2 Declarations of Interest

2.1 There were no declarations of interest.

3 Minutes of the Meeting held on Thursday 18th October 2012

3.1 The minutes were approved as a true and correct record.

4 Matters Arising

The CCG noted the matters arising.

5 Gloucestershire Clinical Commissioning Group (CCG) Shadow Board Chair's Report

5.1 The report highl ights some of the activities of the Chair since the Committee last met.

5.2 Further to the wri tten report, a verbal update was given which included:

- GP Engagement event on 11/10/12 was well attended by 60 pl us practices out of 85. The event was a chance to share the CCG vision and the 5 year Your Health Your C are strategy, as well as sharing work on clinical programmes.
- Senior management positions are now being appointed.
- Authorisation vi sit on 20/09/12. T he outcome for moderation has now been rec eived. The C CG will be advised of the authori sation outcome by the Commissioning Board on 05/12/12.

5.3 <u>RESOLUTION</u> - The CCG noted the report.

6 Presentation: Health & Wellbeing Consultation

6.1 The Director of Public Health introduced the presentation which included a summary of the key points relating to Fit for the Future - a 20 year Health and Wellbeing Strategy for Gloucestershire, and the 5 year Strategy for Care and Services entitled - 'Your Health, Your Care'.

6.2 It was noted that the presentation aimed to set out the clear links between the 2 strategies and set out the priorities for improving health and well-being as well as looking at how support and services could change in the next 5 years. To view the presentation follow this link: \\Glos\pct\Commissioning\Cluster Governance\6) Gloucestershire CCG\2012\Presentations\CCG meeting Nov15th 2012.pptx

6.3 Questions and discussion points included:

- How do you define the concept of community? It was felt that most people are members of many communities. A piece of work has just been commissioned with the University of Gloucestershire looking at how people see themselves within different neighbourhoods, and community as place.
- Discussion followed on virtual communities, social media and how to promote social inclusion.
- Alcohol has been shown to have a link with lowered IQ, how can we ensure this is included? Need to ensure we use our normal mechanisms to cascade out best evidence as it appears without always waiting for annual refresh of strategies etc.
- Need to ensure best value. Need to be more explicit with secondary care physicians about how value is extracted. CCG supportive of focus on prevention
- How are we going to benchmark against other European countries? Is the CCG being asked to commit to a 20 year strategy? Yes the CCG has been part of developing a 20 year strategy – it is the vision of a healthier Gloucestershire with reduced health inequalities that the CCG is being asked to commit to over a 20 year period, taking necessary action over 1- 3 years in a rolling cycle.
- The CCG wants to reduce inequalities. Marmot's evidence based review suggests that ensuring good health in the 0-4 age group is a priority.
- Honesty with the public and stakeholders about financial constraints and involve them in commissioning decisions. Openness and transparency required in decision making process.

6.4 **<u>RESOLUTION</u> - The CCG Shadow Board noted the presentation. The DPH said that all responses to the consultation would be considered by the HWBB in December and January and CCG members' views would be welcomed.**

7 Performance against Commissioning Report

7.1 The Director of Finance introduced the report which provides a strategic overview of the financial and service performance issues by exception.

It was noted that the report sets out the financial position as at the end of October 2012.

7.2 Discussion took place with regard to Appendix 8 Annual Operating Plan – Quarter 1 performance. It was noted that there are 48 greens, 8 ambers and 1 red traffic light.

7.3 The CCG noted that the 4 hour A&E target has now been green for 6 months. Work is taking place to improve ambulance targets.

7.4 Key areas were set out for elective targets:

- Percentage of Trauma and Orthopaedic (T&O) admitted Pathways treated within 18 weeks – Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) maintained 88.9% performance during October. On target to deliver 90% (full compliance) by Quarter 3.
- Percentage of patients who have waited more than 6 weeks for one of the 15 key diagnostic tests – breaches fell to 90 patients in line with recovery plan. A clinical audit will take place on each of the 90 breaches and the impact on patients.

- Percentage of patients seen within 2 weeks of an urgent referral for suspected cancer – performance moving to a green position.
- At least 85% of patients receiving first definitive treatment for cancer should be seen within 62 days from an Urgent GP referral – this target was missed by 1 patient in September.
- CDiff – remains a challenge. Looking at antibiotic prescribing, working on reviewing antibiotic formulas, continuing to do Root Cause Analysis (RCA) on all community cases (pre-48 hour).
- 30% reduction in ambers and reds is welcomed.

7.5 Winter plan – has now been signed off by the Integrated Governance Committee and scrutinised by the Strategic Health Authority (SHA) for complications. It is a coherent capacity plan that takes account of demand.

7.6 Funding of 'Warm and Well' grants.

7.7 Concerns were raised with regard to underachieving in immunisation.

7.8 Discussion took place on workforce issues. This included a brief update on the Commissioning Support Unit (CSU). The PCT is in the process of agreeing a Service Level Agreement (SLA) for all services commissioned from the South Central CSU.

7.9 Brief discussion took place on Long Term Conditions (LTC). It is expected that the target for Stroke Services will go green for November as there has only been 1 breach.

7.10 A brief financial overview was given. It was noted that the PCT is on target to deliver a surplus of £8.9m against an anticipated revenue resource limit of £961.2m.

7.11 <u>RESOLUTION</u> - The Shadow Board noted the reported financial position for 2012/13 and the performance against the 2012/13 national targets and the actions taken to ensure that performance is at a high standard.

8 QIPP Programme Update

8.1 The CCG Shadow Board was provi ded with an update of progress against the QIPP themes and main programmes of work, identi fying progre ss to date, key risks and proposed remedial actions.

8.2 NHS Gloucestershire has a requirement to del iver £29.8m recurrently from its QIPP programme, to ensure financi al stability moving i nto 2012/13. There are 71 programmes under this remit.

8.3 Key risks as set out on page 8 were outlined.

8.4 Discussion took place regarding the £400,000 cost pressure on GPs from pharmaceutical companies for the epilepsy drug Phenytoin which has i ncreased from £2.80 to £65. A request was made to put the behaviours of some pharmaceutical companies into the publi c domain by raising the issue at national level. It was agreed that it was right to m ake this a matter of public record. The CCG will write a letter to the pharmaceutical companies in question.

8.5 <u>RESOLUTION</u> - The Shadow Board noted the performance against planned QIPP programme and the proposed remedial actions.

9 Any Other Business

9.1 CCG members were reminded that there will be a change to the tel ephone numbering syst em from November 26th for NHS Gloucestershi re, Gl oucestershire Care Servi ces and Gloucestershire Hospitals NHS Foundation Trust which are currently prefixed with 0845 to 0300.

9.2 The meeting was i nformed that the contract for the Out of Hours Service is up for tender. It is aimed that the servi ce specification contract will be out by the end of this month. The CCG was asked to del egate consent to the Programme Board to work on the service specification and bring back the i nformation to the December Shadow Board.

9.3 The above recommendation was agreed.

10 Public Questions

10.1 Mark Nurse – paramedic

Mr Nurse raised a question in relation to the problem of patients being brought back to hospital after being discharged too early. He claimed that costs are being incurred on the ambulance service. The question also related to the Single Point of Clinical Access (SPCA) and how every patient has to come through the Accident and Emergency Department (A&E). Concerns were raised about the size of A&E and it not being able to cope with the amount of patients coming through the system.

10.2 Assurance was given that the PCT is working closely with the Director of Operations at GHT to ensure that the above problems are addressed by the Winter Plan. A number of measures have already been implemented including extra investment in re-ablement, nursing and domiciliary care. Meetings are taking place every other week. Work is underway with the Great Western Ambulance Service (GWAS) regarding capacity issues.

The key is to make sure community hospital utilisation takes place. It was noted that this a whole system problem which starts with GPs. Every practice is signed up to the Primary Care Foundation Programme. Problems need to be owned by the clinical community. Progress is being made with reducing admissions from care homes into hospitals. The Unscheduled Care Provider Group includes members of the public and representatives of GWAS, issues of concern can be brought to this group. It was also noted that re-admissions are being audited.

10.3 Mr Nurse also raised concerns with regard to end of life care. He claimed that agreements are not being made in nursing homes between the patients and the GPs. Ambulance staff feel that it is not very dignified to carry out Cardiopulmonary Resuscitation (CPR).

It was noted that special work is being carried out in this area. Two nursing homes have been identified across the county as well as GPs to work on the project.

10.4 Ken Power

I acknowledge that everyone has a responsibility for their health, as do communities, but is the corporate responsibility behind this being addressed?

It was noted that the extent to which any council chooses to focus on this issue will be determined by the political leadership which has the mandate to do so.

10.5 David Penny

Has the CCG planned to take responsibility (through the Joint Strategic Health & Wellbeing Strategy) for 20 years?

Yes, our strategy sits under the Health & Wellbeing Board, we are owning this as a community, we are signed up to the principle and will work in the future together.

10.6 Caroline Malloy (Stroud v Cuts/38 Degrees)

In relation to the QIPP Programme - What is the source of investment and how much is it anticipated it will be necessary to use this?

Quite a lot of programmes are amber and red is there information about that?

As part of the NHS Operating Framework 2011/12 PCTs set aside 2% of their resources as uncommitted headroom. This fund is then used to pump prime service re-design and supports transition arrangements.

The Board paper highlights key risks and issues around QIPP schemes.

11 Date and time of next meeting

11.1 Thursday 20th December 2012 between 2pm and 5pm i n the Board Room at Sanger House.

11.2 The meeting closed at 3.31pm.

Minutes Approved by the CCG Shadow Board.

Signed (Chair):_____ Date:_____

Matters arising from previous Gloucestershire Clinical Commissioning Group (Shadow Board) Meetings November 2012

Item	Description	Response	Action with
13.9.12 Agenda Item 6	CCG Shadow Board GP Member Reports	It was agreed that a workin g group comprisi ng GPs and members of the Fi nance Team be established in order to ascertain which information needs to be reported. Dr Hein le Roux and Dr Jeremy Welch were volunteered to si t on this group. It is likely the group will meet for the fi rst time in November. Update: i n the process of arranging meeting between Hein, Jeremy & Cath Leech. Waiting for availability.	**Chair** **Ongoing** **January**
18.10.12 Agenda Item 7	Carers Commissioning Strategy	Briefing by the Commissioning Director, Chil dren, to be circulated shedding light on how issues involvi ng children as carers are tackled. Mark Branton/Martin Gibbs/Shona Arora to ensure caveats relating to chil dren as carers and future funding are worked in to the final report. Becky Parish to update t he CCG at the end of t he Consultation, report back to December Shadow Board.	**MB** **MB/MG/SA** **Completed**

15.11.12 Agenda item 8	QIPP Programme Update	Discussion took place regarding the £400,000 cost pressure on GPs from pharmac eutical companies for the epilepsy drug Phenytoin which has increased from £2.80 to £65. A request was made to put the behaviours of some pharmaceutical companies into the public domain by raising at national level. It was agreed that it was right to make this a matter of public record. CB to contact the Department of Health and Office of Fair Trade. CCG members to use contacts and sources of influence to alert others about this and related issues.	**CB**

NHS Gloucestershire

Agenda Item 5

Gloucestershire Clinical Commissioning Group (Shadow Board)

Board Meeting Dates	**Thursday, 17th January 2013**
Title	**Gloucestershire Clinical Commissioning Group (GCCG) Shadow Board Chair's Report**
Executive Summary	This report outlines the key issues addressed by the Gloucestershire Shadow CCG and in November and December 2012.
Key Issues	The key issues arising include: • Patient and Public Engagement • Decision on Options Appraisal for Out of Hour's Service • Countywide Locality Executive Meeting • North Devon and GCCG Development Session • The Constitution • Priorities for the Next 6 Months
Risk Issues	Appointment of Lay Representative (Governance) within proposed GCCG
Financial Impact	None
Legal Issues (including NHS Constitution issues)	None
Impact on Equality and Diversity	None
Impact on Health Inequalities	None
Impact on Sustainable Development	None
Patient and Public Involvement	
Recommendation	**This report is provided for information and both Shadow Boards are requested to note the contents.**
Author	Dr Helen Miller
Designation	Gloucestershire CCG Chair (Shadow)
Sponsoring Director (if not author)	

NHS Gloucestershire Shadow Board Meeting

Gloucestershire Clinical Commissioning (GCCG)
Chair's Report

1 Introduction

1.1 This report outlines the key events discussed and attended by Gloucestershire CCG in November and December.

2 Patient and Public Engagement

2.1 GCCG met with Gloucestershi re LINk and discussion took place regarding their current role, meetings held around the county and the differences between LINk and the future HealthWatch organisation. GCCG are currentl y awaiting notification who will replace LI Nk as a Social Enterprise organisation followi ng Gloucestershire County Council tender process for HealthWatch.

2.2 During November GCCG had a presentation from the Gloucestershire R ural Com munity C ouncil who outlined the role of G loucestershire Vill age and Community Agents who provide support to older people (over 55's) i n Gloucestershire, and signposts cli ents to inform ation and servi ces withi n the county.

2.3 Discussion has taken plac e regarding the engagement opportunities and challenges fa cing GCCG, along with the key option formers and mi lestones for engagement during 2013-14.

3 Decision on Options Appraisal for Out of Hour's Service

3.1 A decision has been reached followi ng in-depth discussion on the opti ons apprai sal for the OOH's servi ce. Option 4 was approved which covers the tendering of the full primary care OOH's services, cover of urgent medical problems in a community hospital but excluding Minor Injuries Units.

4 Countywide Locality Executive Meeting

4.1 The aim of the session was to li sten to issues rai sed by the Locality Executives and in turn update them on the work undertaken on the commissioni ng pl ans for 2013/14 to date. GCCG wish to ensure that l ocal priorities are included i n all future commissioning decisions and how localities are involved in decision making.

4.2 The meeting was well received and it was agreed to meet up

on quarterly basis.

5 North Devon and GCCG Development Session

5.1 GCCG met with Northern Devon CCG to share learning and experience to date. The afternoon covered:

- Transforming community services and the work underway in North Devon
- Asset based approach to care which encompassed the current Living Well Project for Gloucestershire
- Gloucestershire's approach to commissioning in the future
- Health challenges faced by both organisations
- Financial planning assumptions for 2013/14 and
- The actions and next steps to be taken.

5.2 Both organisations found the afternoon really useful and see opportunities for greater sharing. It is planned to keep in touch and if possible to visit some specific areas of work.

6 The Constitution

6.1 All 85 member GP practices have now signed up to the Gloucestershire CCG constitution following a comprehensive consultation exercise with member practices, the Local Medical Committee, British Medical Association and community partners.

6.2 The document was developed in line with the NHS Commissioning Board's model constitution and is extremely strong and clear in the areas of accountability, transparency – including transparency in procurement, public engagement and decision making.

6.3 The constitution contains appropriate references and safeguards to support how the CCG's work is carried out on behalf of the people of Gloucestershire.

6.4 The document will be subject to some small technical updates prior to 1st April 2013.

7 Priorities for the Next 6 Months

GCCG have identified their priorities for the next 6 months particularly around: the infrastructure, planning and delivery.

7.1 Infrastructure

This will incorporate working with the Commissioning Support Unit, the governance structure, financial scheme of delegation and development programme for staff.

7.2 Planning

A stocktake of 'Your Health Your Care', the Annual Operating Plan and Clinical Programme Groups and ensure that clear and credible plans are in place before 1st April 2012.

7.3 Delivery

A full review of Local Enhanced Services as monies will transfer to GCCG after 1st April 2013.

8 Recommendations

This report is provided for information and the Shadow Board is requested to note the contents.

NHS Gloucestershire

Agenda Item 6

Gloucestershire Clinical Commissioning Group (Shadow Board)

Meeting Date	**Thursday 17th January 2013**
Title	**Gloucestershire Clinical Commissioning Group Shadow Board GP Member Reports**
Executive Summary	This report aims to provi de the C CG Shadow Board with progress reports from local executives. Members are reminded that the CCG is operating as a Sub-Committee of PCT Board. Currentl y it is shadow form and will take over the PCTs current functions from March 2013. This report provides updates from North Cotswold and Gloucester City localities.
Key Issues	The aim of each locality GP member report is to: • Provide Board member assurance of wider GP engagement within the localities • Track del ivery within local ities (supported by financial and activity in formation provided by the PCT) • Highlight positive developments within the locality that the wider Board membershi p needs to be aware of • Raise any emerging issues of concern.
Risk Issues: Original Risk Residual Risk	None identified.
Financial Impact	The report includes fi nancial activity within localities which impacts on financial position. The overall position is reflected in PCT Cluster Finance & Performance Report.

excellence

www.nhsglos.nhs.uk

Legal Issues(including NHS Constitution)	None.
Impact on Equality and Diversity	None.
Impact on Health Inequalities	Report shows work within locali ties to address health inequalities.
Impact on Sustainable Development	None.
Patient and Public Involvement	Reports include updates on engagement.
Recommendation	The CCG Shadow Board is asked to note this paper.
Appendices	GP member reports • Appendix 1 – Gloucester City • Appendix 2 – North Cotswold
Author	Mark Walkingshaw
Designation	Deputy Accountabl e Officer/Director of Commissioning Implementation
Sponsoring Director (if not author)	

Gloucestershire Clinical Commissioning Group (Shadow Board) GP Member Report From Dr Will Haynes – Gloucester Locality

1 Achievements

1.1 Gloucester Locality has made signi ficant progress at Executive and Locality-wide levels in focussing on a Gloucester Locality Community Care Plan. This strategic docum ent brings together ideas from across the city and its practices, explored in a locality workshop and developed with member practices at the last Gloucester Forum.

Gloucester Locality Community Care Plan

Building on the Gloucester JSNA (Joint Strategic Needs Assessment) and the "Your Health, Your Care" collaboration between the county's health commissioners, Local Authorit y and health prov iders, the plan highlights areas including :

Housebound patients
Patients in Residential and Nursing Homes
Deprivation
Multi- cultural and multi-language aspects of care delivery
Palliative Care and advanced care planning
Long-term condition care including the developm ent of " Integrated Community Care Teams" between heal th and social care, along with patient key-workers as part of the "Living well " project .
Communication improvements to support patients, their carers and their clinicians for example increas ing cl inical information sharing between clinicians over the "Out- of- Hours" ti mes of the week, s o assisting clinical decision making and continuity of care.

Gloucester GPsI Dermatology Service

This recently procured service enables Gloucester's patients to benefit from a consultant triage servic e for skin care and specialist GPs with experience to care for pat ients in the community in Gloucester City, with shorter waiting times. If successful, this service may be a model on which to base a similar countywide service.

2 Engagement

2.1 3rd October- **Protected Learning Event for GPs and Nurses**

Presentations about several schemes developed locally including :

Community Respiratory, Heart Failure, Diabetes , Heart Failure Telehealth and Intravenous therapy services; Expert Patient Programme and a consultant update on the management of Benign Breast Disease.

11th October- **CCG Engagement Event at Cheltenham Racecourse**

Engagement and presentations by the CCG Shadow Board members to stakeholders from Primary Care, patient groups, commissioning managers and representatives of organisations delivering health and social care across the county.

4th December- **Gloucester City Locality Forum**

Advanced briefing about forthcoming county-wide meeting for Locality Executives enabling practices to consider issues relating to ;

Financial accountability , contingency planning at locality and CCG- wide levels , opportunities for investment in services at locality and CCG- wide levels and strategic planning based on balancing clinical budgets under the new CCG era of “Fair shares”.

The forum, representing all practices, was able to share feedback from practice clinicians and the Locality Executive and prepare a response for the county-wide meeting on 6th December.

Presentation from the Locality Executive about a proposed Locally Enhanced Service supporting improvements in collaboration between Primary Care Clinicians and Care Homes to the benefit of their shared patients, supporting the aspirations of the Gloucester Community Care Plan.

6th December- **CCG- wide meeting of Locality Executives** at which Gloucester had a strong representation and presented feedback from Gloucester City Locality Forum and raised suggestions relating to Care Homes, financial accountability and planning.

Weekly meeting of the Gloucester Locality Executive including its new members and chair and its CCG Locality lead GP.

3 QIPP Delivery

3.1 **See attached document**

4 Activity Report

4.1 **See attached document**

5 Financial Position

5.1 **See attached document**

6 Key Issues

6.1 **See attached document**

7 Next steps/milestones for locality work

Development and wider engagement relating t o the Gloucester Community Care Plan.

8 Latest locality financial position including QIPP delivery

8.1 **See attached document**

9 Latest activity position – highlighting key variances against commissioned levels of activity.

See attached document

Appendix 1

Gloucester City Locality Summary Finance Report 2012/13 – Month 6

1. Overall Briefing Summary

The overall budget allocation for Gloucester City in 2012/13 is £193m. £1.5m of this is non-recurrent support. The year to date position for the locality is showing an over spend of £1.627k or +1.71%. Those practices with a variance of +/- 5% are highlighted in the below table.

	2012/13 Budget Total	Year to date budget	Year to date expenditure	Year to date variance	Year to date variance
	£	£	£	£	%
Locality Report	£192,696,564	£95,141,533	£96,768,592	£1,627,060	1.71%
Bartongate Surgery	£11,311,502	£5,59 1,415	£5,47 9,903	-£111,512	-1.99%
College Yard and Highnam	£6,091,219	£2,96 6,490	£2,948,779	-£17,710	-0.60%
Pavilion Family Doctors	£14,733,549	£7,28 2,897	£7,25 9,271	-£23,627	-0.32%
Heathville Road Surgery	£13,166,722	£6,50 2,756	£6,48 3,692	-£19,063	-0.29%
Hadwen Medical Practice	£19,087,616	£9,43 3,139	£9,41 1,909	-£21,230	-0.23%
Saintbridge Surgery	£9,683,394	£4,78 4,113	£4,774,380	-£9,733	-0.20%
London Road Medical Practice £8,11	0,905	£3,974,295	£3,97 4,294	£0	0.00%
Gloucester City Health Centre £10,5	81,028	£5,231,916	£5,29 0,936	£59,020	1.13%
Cheltenham Road Surgery	£9,763,991	£4,82 1,848	£4,876,658	£54,809	1.14%
Churchdown Surgery	£15,121,664	£7,47 6,514	£7,59 3,899	£117,384	1.57%
Matson Lane Surgery	£3,098,873	£1,53 2,867	£1,565,647	£32,781	2.14%
Hucclecote Surgery	£11,416,214	£5,631,884	£5,76 4,443	£132,559	2.35%
Barnwood Medical Practice	£7,570,286	£3,74 0,980	£3,848,202	£107,222	2.87%
Kingsholm Surgery	£6,797,163	£3,360,147	£3,46 0,433	£100,286	2.98%
Brockworth Surgery	£10,521,004	£5,19 7,743	£5,37 4,015	£176,272	3.39%
Longlevens Surgery	£7,158,082	£3,533,826	£3,68 6,504	£152,678	4.32%
Rosebank Surgery	£24,188,971	£11,954,095	£12,547,138	£593,044	4.96%
Quedgeley Medical Centre	£3,429,034	£1,69 5,712	£1,866,068	£170,355	10.05%
Gloucester Health Access Centre £86	5,348	£428,896	£562,423	£133,526	31.13%

At month 6 £667k of the non recurrent support has been allocated to support the following practices:-

Churchdown Surgery – £412k
Brockworth Surgery – £78k
Barnwood Medical Practice – £74k
Matson Lane Surgery – £62k
London Road – 41k

Key locality variances:

- Specialties that have seen an increase in activity across the locality compared to month 6 2011/12 activity levels are detailed below

Planned Care (Elective Inpatients):

Clinical Haematology
Gastroenterology
Ophthalmology

Unscheduled Care (Non Elective Inpatients):

Obstetrics
Diseases of Childhood and Neonates
Cardiac Surgery and Primary Cardiac Conditions

Planned Care (Outpatient Activity):

Gynaecology
Ophthalmology
Palliative Medicine

Gloucester City Locality Finance Report 2012/13 – Month 6

2. Financial position within Acute Commissioning

2.1 Elective

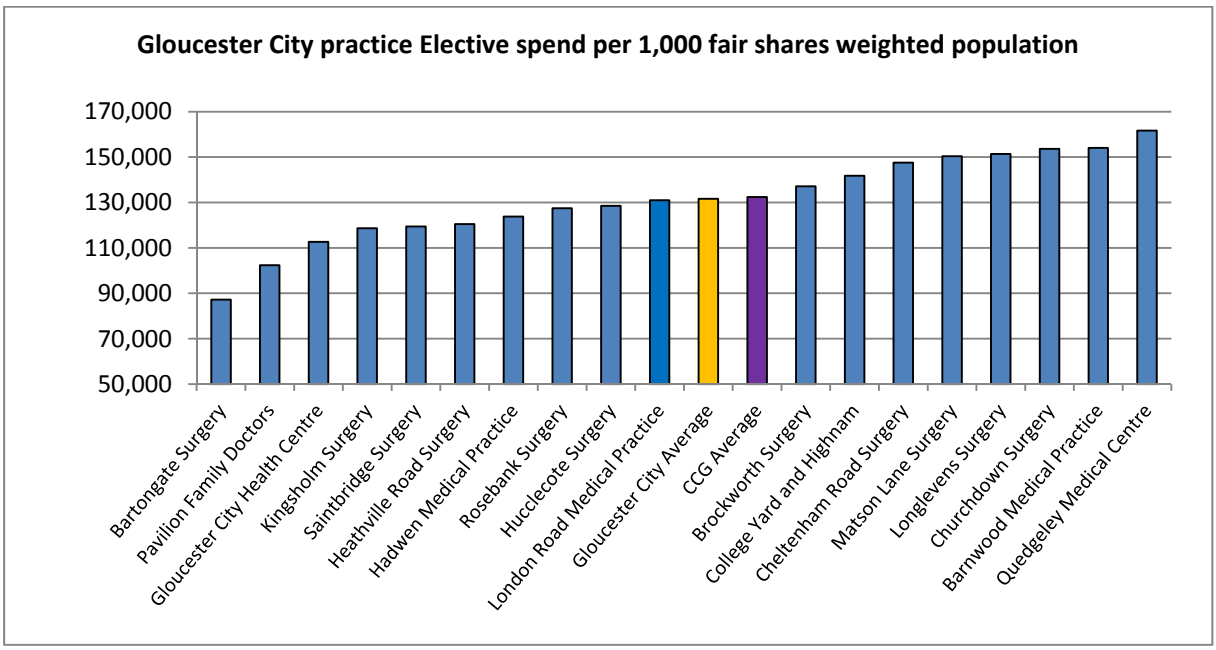
The Gloucester City locality month 6 elective is showing an under spend of £413k. Once the QIPP requirement of £185k is factored in it is an under spend of £228k. (Compared to -£502k at month 5)

GHFT is showing a pre-QIPP under spend of £461k.

Further details on the key variances between 2011/12 and 2012/13 for Elective Inpatients Care are shown below:-

Planned Care (Elective Inpatients):
Colorectal Surgery (£132k / 68 activity)
Ophthalmology (£134k / 166 activity)
Cardiology (£86k / 49 activity)
Gastroenterology (£92k / 144 activity)
Trauma & Orthopaedics (-£83k / -75 activity)
Gynaecology (-£129k / -123 activity)

The below chart shows Gloucester City practices elective spend per weighted 1,000 population alongside both CCG and the locality average. The Gloucester City locality average on elective spends per fair shares weighted 1,000 is slightly below the CCG average. (It was slightly above last month)



2.2 Emergency

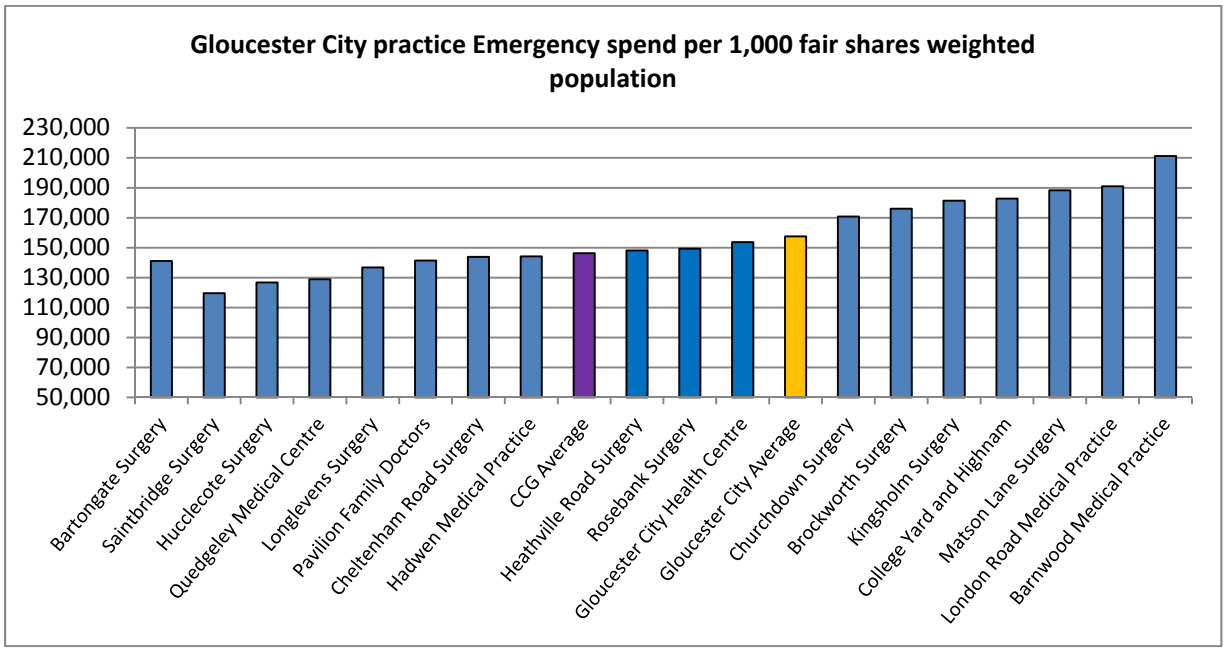
The Gloucester City locality month 6 emergency is showing an overspend of £690k once the QIPP requirement of £570k is factored in it is an overspend of £1,260k. (Compared to £991k at month 5)

GHFT has a pre-QIPP overspend of £775k which is partially offset by UBHT under spend of £113k.

Further details on the key variances between 2011/12 and 2012/13 for Non Elective Inpatients Care are shown below:-

Unscheduled Care (Emergency Inpatients):
Obstetrics (£319k / 292 activity)
Nervous System (£186k / 76 activity)
Diseases of Childhood and Neonates (£136k / 194 activity)
Skin, Breast & Bums (-£79k / -31 activity)
Female Reproductive System (-£56k / -56 activity)

The below chart shows Gloucester City practices emergency spend per weighted 1,000 population alongside both CCG and the locality average. The Gloucester City locality average on emergency spends per fair shares weighted 1,000 is above the CCG average.



2.3 Other Non Elective (Maternity & Transfers)

The Gloucester City locality month 6 other non-elective is showing an overspend of £186k (Compared to £386k at month 5) has seen a significant decrease from Month 5.

2.4 Outpatients

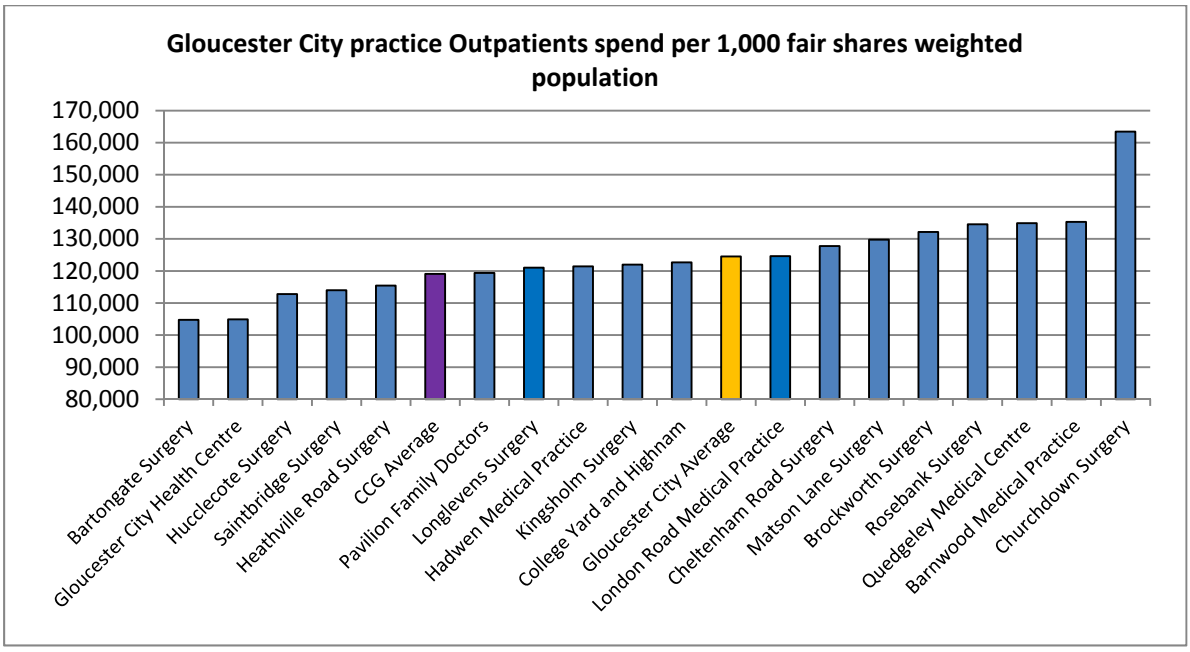
The Gloucester City locality month 6 outpatients is showing an under spend of £380k once the QIPP requirement of £381k is factored in it is an over spend of £1k. (Compared to -£109k at month 5)

GHFT has a pre-QIPP under spend of £310k.

Further details on the key variances for Unscheduled Care are shown below:-

Planned Care (Outpatients):
Gynaecology (£35k / 180 activity)
Ophthalmology (£43k / 435 activity)
Palliative Medicine (£33k / 181 activity)
Trauma & Orthopaedics (-£99k / 298 activity)
Vascular Surgery (-£54k / -421 activity)

The below chart shows Gloucester City practices outpatients spend per weighted 1,000 population alongside both CCG and the locality average. The Gloucester City locality average on Outpatients spends per fair shares weighted 1,000 is above the CCG average.



2.5 A&E/MIU

A&E/MIU is showing an over spend of £19k. (Compared to £7k at month 5)

3. Prescribing

The GP prescribing Gloucester City locality month 6 year to date position including QIPP target is at £402k overspent.

This position, does not forecast any Locality work to decrease Prescribing activity and costs. If work continues to be carried out in the locality should improve this forecast.

This position is an improvement compared to the same time last year, even with the savings targets attributed to the prescribing budgets.

This is based on Four month's actual activity. This position will be updated on a monthly basis as more actual information becomes available.

Additional information for localities around their prescribing costs is sent out by NHS Gloucestershire Medicines Management Team.

4. Key messages and summary of recommendations

4.1 Cluster summary

The Gloucester City locality commissioning over spends in 2012/13 has been contributed mainly by the Planned Care Elective Admitted Care being under spent and the Emergency overspend both at Gloucestershire Hospitals NHSFT and University Hospitals Bristol NHSFT.

Emergency Admissions and Emergency QIPP are starting to cause a very significant pressure within the locality and county wide due to the effects of the profiling.

4.2 Using UKSH Activity

Year to date Gloucester City has underutilised the UKSH block contract by £676k. This in an increase in underutilisation of £139k between Month 5 to month 6

£181k worth of activity has gone to UKSH compared to £202k in 2011/12 this is an decrease of £21k No activity has gone though UKSH since Month 5.

Any activity that goes to UKSH would result in savings against other providers.

Appendix 2

Gloucestershire Clinical Commissioning Group
(Shadow Board) GP Member Report for North Cotswolds January 2013

1. Achievements

New management team for North Cotswolds Cluster takes over in 2013 – Dr Jacquie Williams as Chair and Amanda Goode, Practice Manager, both from Chipping Campden Surgery. Dr Caroline Bennett will remain on management team in her capacity as CCG liaison member for the North Cotswolds. Preparatory work for handover has taken place.

North Cotswolds Hospital and Jubilee Lodge Intermediate Care Unit fully operational and care pathways being continually refined. Work has started on The George Moore Clinic in Bourton, which will provide another comprehensive Outpatient facility.

All practices continue to Peer Review Outpatient Referrals in all specialities and audits of emergency admissions are underway. Practices are also reviewing their procedures for updating special notes on Adastra and familiarising GPs with INNF procedures. All practices have met with the Primary Care Foundation after completing the practice data and are considering what changes need to be implemented to improve access and assessment of urgent cases.

2. Engagement

Another locality PLT was held in the autumn attended by nearly all the GPs from all practices. Clinical topics covered included stroke presented by Dr Kumar and "funny turns" presented by Dr Deering. Both of these impact on Emergency admissions and outpatient attendances. The Community IV team also attended and discussed conditions appropriate for referral and how the service can be expanded in the North Cotswolds to include transfusions. A blood fridge is being purchased for the North Cotswolds Hospital to facilitate this. An initial discussion took place regarding the development of Integrated Care teams in the North Cotswolds with the Locality Manager, Caroline Wood and her team and this will be progressed by Dr Hywel Furn-Davis on behalf of the Cluster. The cluster has also had meetings with Harmoni and Dr Jeremy Welch regarding NHS 111 implementation.

All practices have signed the CCG memorandum of understanding, and a number of GPs attended the countywide engagement event.

The Cluster Business plan has been updated to reflect current work streams, financial input still awaited from the PCT before it can be finalised.

A strategy for wider community engagement is being developed with the North Cotswolds Locality forum taking on a wider stakeholder engagement function – members include healthcare professionals- GPs, physios, HVs, local council representatives, league of friends, dementia advisor etc. Meetings are planned with voluntary sector representatives. The cluster management team has also met with Councillor Topple the portfolio holder for health and discussed local issues.

3. QIPP Delivery

See summary report

Appendix 2

The locality does not have any specific schemes but is actively supporting all countywide schemes which are incorporated into the 2012/13 Business Plan. Dr Healy is actively involved in developing the business case for a primary care inflammatory bowel disease follow up service which will probably need to be a countywide service or at least across a number of localities. The main challenge for the cluster remains Emergency Admissions. Practices are actively supporting schemes such as GWAS non-conveyance and Telehealth.

4. Activity

North Cotswold Locality Finance Report 2012/13 – Month 6

a. Overall Briefing Summary

The overall budget allocation for North Cotswold 2012/13 is £32m. The year to date position for the locality is showing an over spend of £306k or 1.96%. The table below shows practice variances.

Practice Variances

	2012/13 Budget Total	Year to date budget	Year to date expenditure	Year to date variance	Year to date variance
	£	£	£	£	%
Locality Total	£31,800,328	£15,608,674	£15,914,628	£305,954	1.96%
Mann Cottage	£4,568,755	£2,165,359	£2,165,359	£0	0.00%
Bourton and Northleach Surgeries	£10,513,275	£5,188,977	£5,249,582	£60,606	1.17%
Campden Surgery	£4,997,958	£2,469,016	£2,505,143	£36,127	1.46%
The White House	£5,131,216	£2,533,211	£2,617,507	£84,296	3.33%
Well Lane Surgery	£6,589,123	£3,252,111	£3,377,036	£124,925	3.84%

Mann Cottage has £192K additional Non-Recurring Support available for 2012/13, and has utilised £5K in as at month 6.

Key locality variances – Specialities that have seen an increase in activity across the locality compared to M6 2011/12 levels.

Planned Care – Elective; further details below:

General Surgery
Clinical Haematology
Medical Oncology
Ophthalmology

Planned Care – Outpatient; further details below:

Cardiothoracic Surgery
Colorectal Surgery

Appendix 2

General Medicine
Podiatry

Unscheduled Care – Emergency – further details available in section 2.3:

Eyes and Periorbital
Haematology, Chemotherapy, Radiotherapy and Specialist Palliative Care
Mouth Head Neck and Ears
Nervous System

Relative Financial Position - Specialities that have a higher spend per 1000 than the CCG Average – by speciality:

Planned Care - Elective:

Urology £45,703
Colorectal Surgery £27,735
Trauma & Orthopaedics £27,634
Other Specialties £18,051

Planned Care - Outpatient:

Vascular Surgery £27,046
Cardiology £26,988
Clinical Haematology £18,695
General Medicine £14,061

Unscheduled Care - Emergency:

Digestive System £107,578
Musculoskeletal System £87,524
Cardiac Surgery and Primary Cardiac Conditions £80,774
Nervous System £69,446

b. Financial position within Acute Commissioning

1. Elective

The North Cotswold locality month 6 elective under spend is -£95k. Once the QIPP requirement of £29k is factored in it is an under spend of -£66k. (Compared to M5 underspend of -£141K excluding QIPP and -£120k including QIPP).

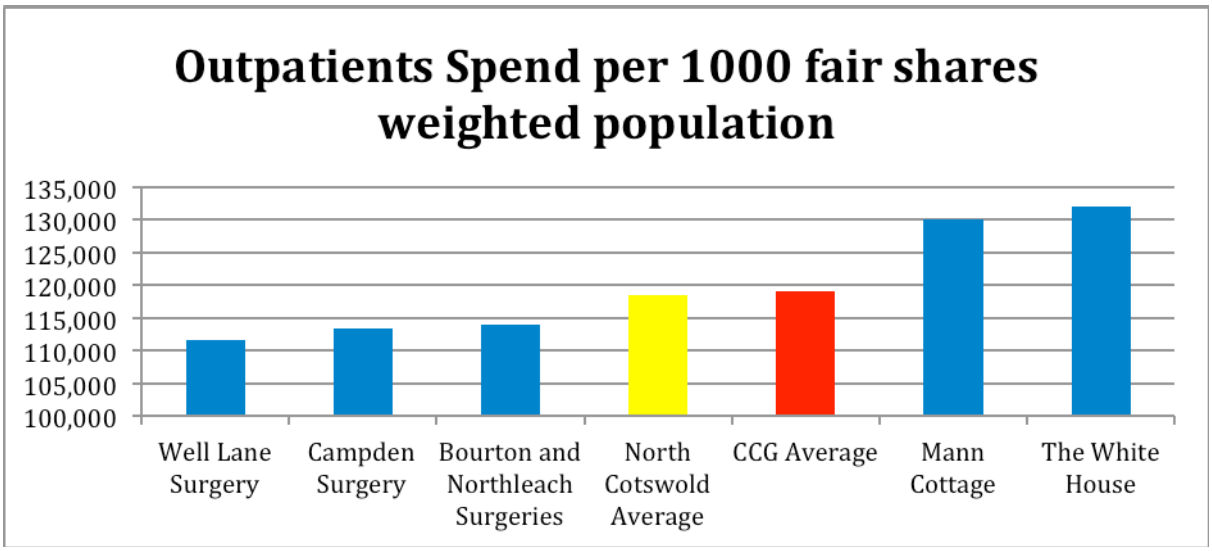
This position is currently being driven by:

GHFT – pre-QIPP under spend of -£84k (-£55k under spend including of QIPP).
Oxford Univ Hosp – under spend of -£7k
University Hospitals Bristol – underspend -£14k
Heart Of England NHSFT – underspend -£11k
North Bristol – Over spend of £21k

Further details on the key variances for Elective Care are shown below:-

General Surgery +£2k (+5 activity)
Clinical Haematology +£5k (+38 activity)
Medical Oncology +£25k (+16 activity)
Ophthalmology +£27 (+24 activity)

The chart below shows North Cotswold practices elective spend per weighted 1,000 population alongside both CCG and the locality average. The practice with the highest elective spend per fair shares weighted 1,000 population is Mann Cottage. The locality average elective spend per fair shares weighted 1,000 is below the CCG average.



2. Outpatients

The North Cotswold locality month 6 outpatients over spend is £32k and once the QIPP requirement of £54k is factored in it is an over spend of £86k. (Compared to M5 over spend of £12k excluding QIPP and +£52k including QIPP).

This position is currently being driven by the following organisations:

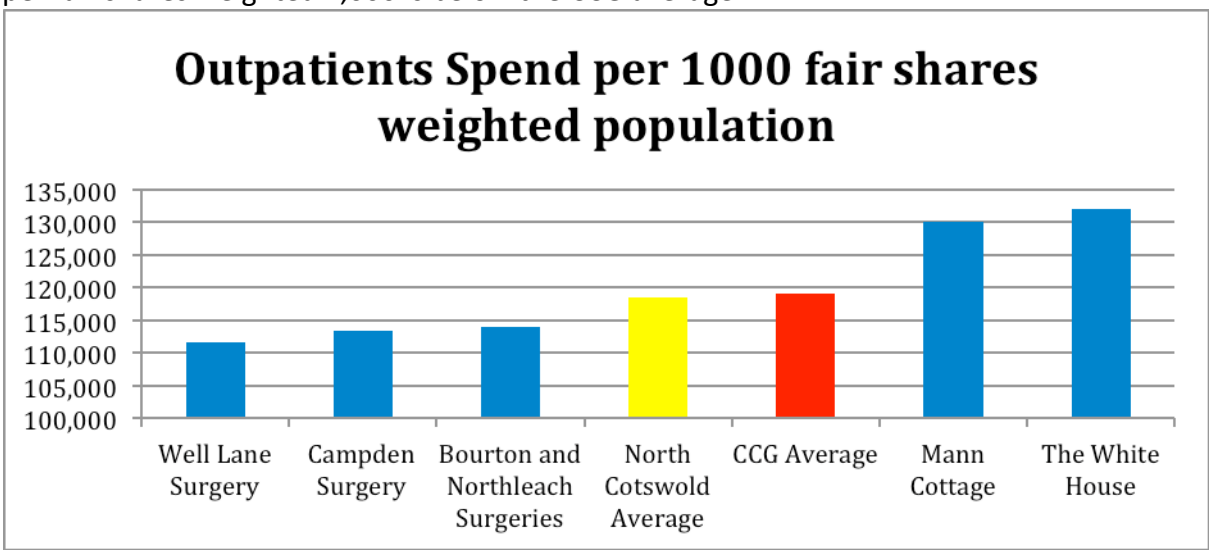
GHFT – pre-QIPP over spend of +£7k (+£61k over spend including QIPP).
GCS – has an over spend of +£30k.

Further details on the key variances for Unscheduled Care are shown below:-

Cardiothoracic Surgery+£2k (+10 activity)
General Medicine +£12k (+68 activity)
Colorectal Surgery +£6k (+34 activity)
Podiatry +£37k (+964 activity)

The chart below shows North Cotswold outpatients spend per weighted 1,000 population alongside both CCG and the locality average. The practice with the highest outpatients spend per

fair shares weighted 1,000 population is The White House. The locality average outpatients spend per fair shares weighted 1,000 is below the CCG average.



3. Emergency

The North Cotswold locality month 6 emergency over spend is +£112k and once the QIPP requirement of £88k is factored in it is an over spend of +£200k. (Compared to M5 over spend of +£99k excluding QIPP and +£166k including QIPP).

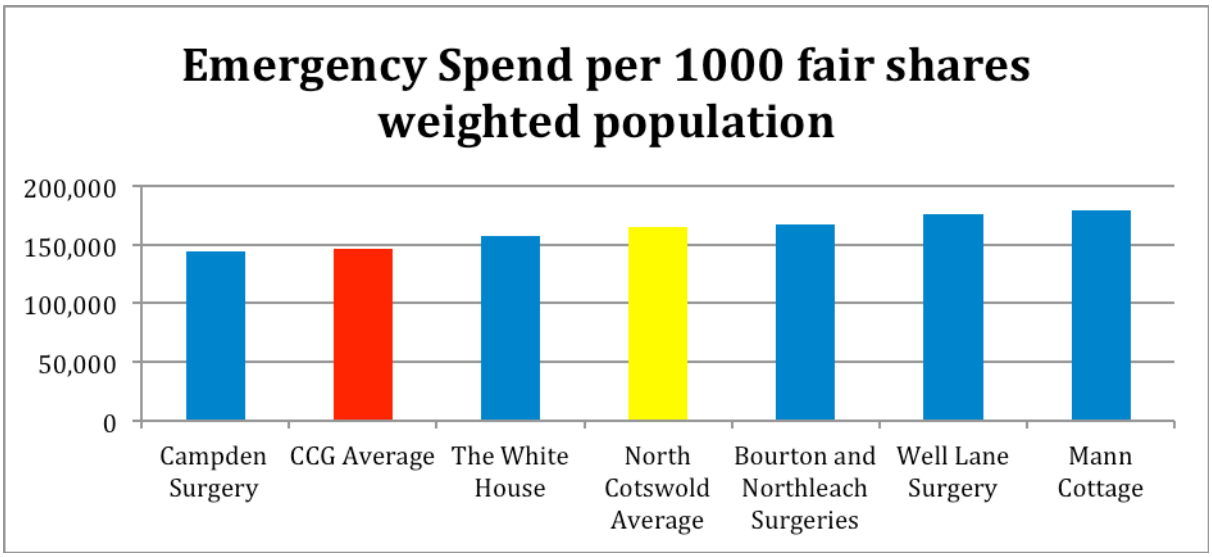
This position is currently being driven by over spends at:

GHFT - has a pre-QIPP overspend of +£143k (+£230k over spend including QIPP)
North Bristol – has a over spend of +£19k
Oxford University Hospitals – has a over spend of +£28k
Gloucestershire Care Services – has an under spend of -£63k
Worcestershire Acute Hospitals NHST – has an underspend of -£10K

Further details on the key variances for Unscheduled Care – Emergency are shown below:-

Eyes and peri orbital +£7k (+2 activity)
Haematology, Chemotherapy etc +£17k (+6 activity)
Mouth Head Neck and Ears +£21K (+3 activity)
Nervous System +£50k (+19 activity)

The chart below shows North Cotswold practices emergency spend per weighted 1,000 population alongside both CCG and the locality average. The practice with the highest emergency spends per fair shares weighted 1,000 population is Mann. The locality average emergency spends per fair shares weighted 1,000 are above the CCG average.



4. Other Non-Elective (Maternity & Transfers)

The North Cotswold locality month 6 other non elective under spend is -£168k compared with an under spend of -£94k at month 5.

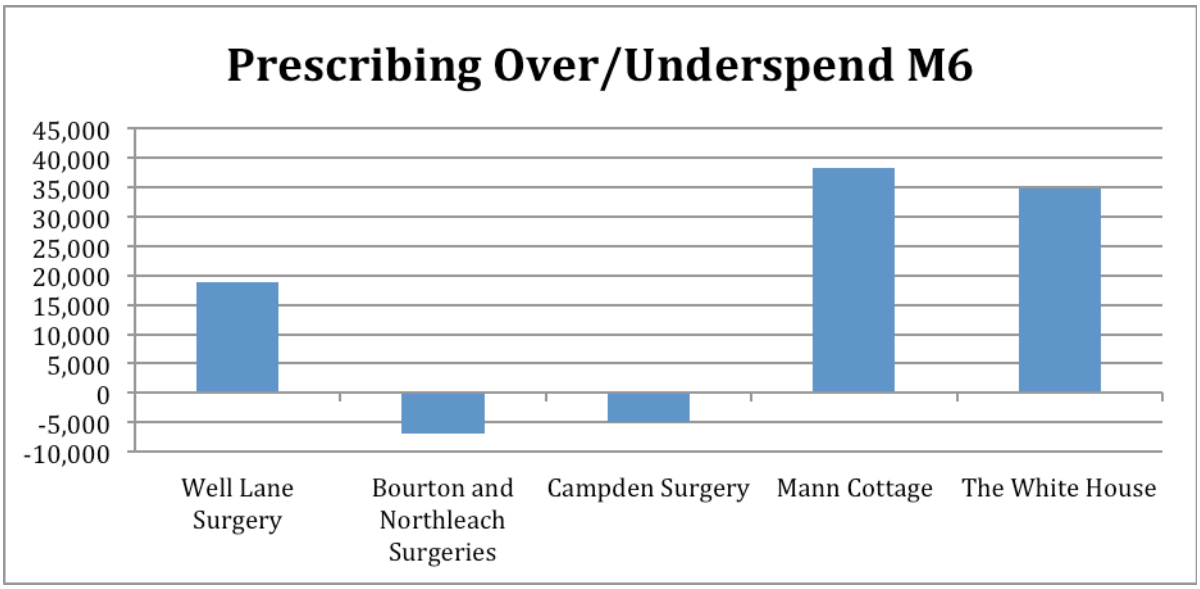
5. A&E/MIU

The North Cotswold locality month 6 A&E/MIU over spend is +£21k compared to +£20k at month 5.

c. Prescribing

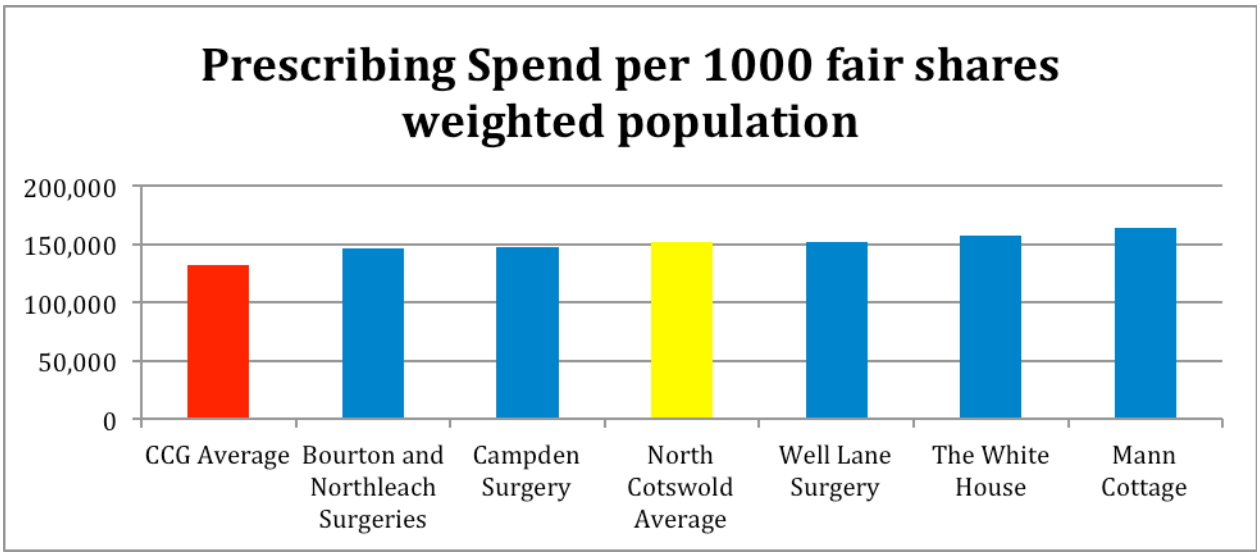
The GP prescribing North Cotswolds locality month 6 position including QIPP target is £80k over spent (3.94%). This is based on four month's actual activity. This position will be updated monthly when further data is received from the Prescription Pricing Authority.

A chart showing the North Cotswold practices under / over spends for prescribing is below:



Appendix 2

The chart below shows North Cotswolds practices prescribing spend per weighted 1,000 population alongside both CCG and the locality average. The practice with the highest prescribing spend per fair shares weighted 1,000 population is Mann Cottage. The locality average prescribing spend per fair shares weighted 1,000 are **above** the CCG average.



Additional information for localities around their prescribing costs is sent out by NHS Gloucestershire Medicines Management Team.

5. Financial Position

See above

6. Key Issues

The spend on emergency admissions remains the largest challenge for the cluster. The countywide delay in roll out of schemes that enhance community resources e.g. community urgent response, ICTs has prevented us from being able to keep more people at home. Increasing direct admissions to our Community Hospital remains a challenge and we are unable to ring fence beds in the North Cotswolds hospital for our patients resulting in increased lengths of stay and more difficult discharged when they are admitted to less local facilities. With the reablement and winter plan schemes being finalised, and ICT development now underway we would hope to see some noticeable improvement in the coming months.

The business case for the North Cotswolds hospital was partly dependent on the repatriation of an increased proportion of GHT outpatient activity from Cheltenham and Gloucester to both our outpatients. The decision to undertake a countywide outpatient review, which is progressing slower than would be hoped has resulted in no local negotiations being possible between community hospitals and GHT. The cluster has been very frustrated by this and is actively discussing provision of outpatients from other local NHS providers.

7. Next steps/milestones for locality work

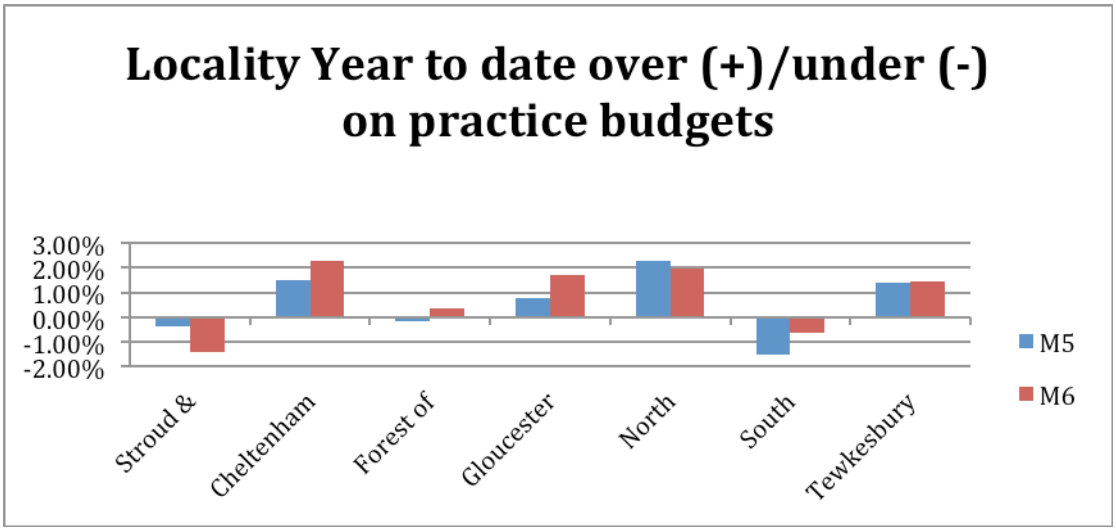
Summary of key areas of focus within the locality:

Appendix 2

Emergency admissions – completion of audits within the practices and actions that result from these.
Implementation of primary care foundation recommendations.
Completion of cluster business plan and its implementation. GP leads assigned for all projects.
Development of improved blood transfusion service at North Cotswolds hospital .
Prescribing - peer review meeting taking place this month.
Cluster Management team handover and development.
Stakeholder engagement
Enhancing local outpatient provision and utilisation of our new facilities
Development of North Cotswolds ICT

8. Latest locality financial position including QIPP delivery

The following graph shows the position at months 5 and 6:



QIPP Summary Report

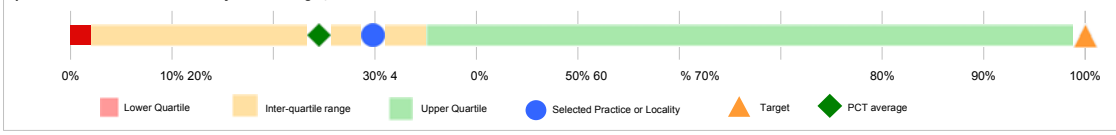
Reporting Period 01-Apr-2011 to 30-Sep-2012

Each quartile on the charts includes a quarter (25%) of practices - the upper quartile includes the top 25% of practices, the interquartile range the middle 50% and the lower quartile the bottom 25%

UKSH

NorthCotswold

a) % Utilisation of Practice/Locality UKSH Budget, 2011/12 YTD



b) Number and cost of inpatient procedures that could be undertaken at UKSH, 2012/13

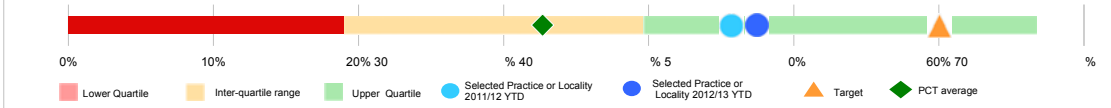
	Actual at UKSH, YTD		Went to other providers, YTD		Total patients needed to go to UKSH to use Annual budget	
	Number	Cost	Number	Cost	Number	Cost
TOTAL	37	£69,364	925	£1,150,289	168	£290,058

'Other provider' data excludes patients <18 and patients who have had an admission for one of the following conditions in the past 6 months:- Diabetes, COPD, Athsma, Epilepsy, Stroke, Cancer, Heart failure, Angina, Renal Failure, Hypertension, Myocardial Infarction and Mental Health conditions

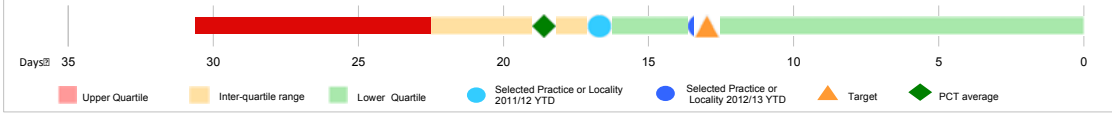
Community Hospital Utilisation**

NorthCotswold

a) % of Community Hospital Admissions that are Direct Admissions



b) Community Hospital Average Length of Stay

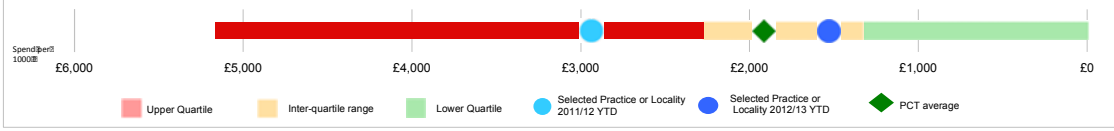


** Target Based on contract with Gloucester Care Services not a Locality specific target

INNF

NorthCotswold

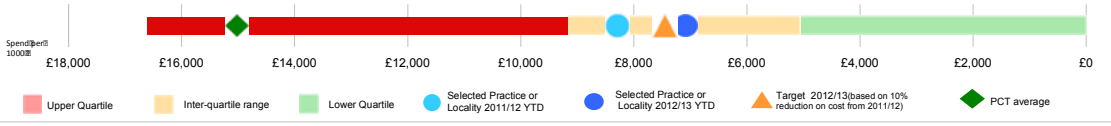
Spend per 1000 population on admissions for low priority procedures



Long Term Conditions Management

NorthCotswold

a) Spend per 1000 population on emergency admissions for COPD, Diabetes, CHD and Heart Failure



	Number					Cost £			
	CHD	COPD	Diabetes	Heart Failure	Other	CHD	COPD	Diabetes	Heart Failure
2012/13 year to date	27	24	3	12	NA	£102,681	£59,097	£3,510	£31,065
2011/12 year to date	24	28	6	15	NA	£86,948	£82,750	£13,627	£46,249
Patients on Telehealth	0	10	4	5	10				

Key Points For:- NorthCotswold

Agenda Item 7

Gloucestershire Clinical Commissioning Group (Shadow Board)

Meeting Date	17th January 2013
Title	Commissioning for Quality Report – Quarter 2
Executive Summary	This quarter 2 report provides Gloucestershire Clinical Commissioning Group (GCCG) with a summary of the three aspects of quality: • Patient and carer experience • Patient safety and risk • Clinical effectiveness The Commissioning for Quality Group (CfQG) assesses, scrutinises, and triangulates data from a wide range of sources in order to seek assurance in relation to the quality of commissioned services. This report summarises the outcomes from the Commissioning for Quality Group, highlights areas of best practice and high quality, as well as any areas of concern or risk along with evidence of remedial action or plans that are in place. It also summarise key policy changes.
Key Issues	As the new CCG structures and ways of working emerge, such as the development of Clinical Programme Groups, we will continue to review and refine the way we assure ourselves of the quality of commissioned services.

	The Quality Strategy will be prepared with the CCG by 31 March, complementing Your Health Your Care, our clinical priorities and building on the strong and effective governance and assurance arrangements that have been in place for some time.
Risk Issues: **Original Risk** **Residual Risk**	There are robust governance arrangements in place to monitor all components of quality, this includes good reporting and alerting arrangements, triangulation and scrutiny of available data or information and early warning measures for all providers.
Financial Impact	The quality indicators included in the Provider contracts include the following financial implications: Commissioning for Quality and Innovation (CQUIN) scheme. Financial penalties for non-achievement of quality and performance indicators.
Legal Issues(including NHS Constitution)	None.
Impact on Equality and Diversity	None.
Impact on Health Inequalities	None.
Impact on Sustainable Development	None.
Patient and Public Involvement	Includes information collected on patient and carer experiences.
Recommendation	Gloucestershire Clinical Commissioning Group Shadow Board are invited to note

	this report.
Author(s)	Becky Parish, Deputy Director Heather Beer, Clinical Quality Lead Alan Potter, Governance & Risk Manager
Sponsoring Director (if not author)	Jill Crook, Director of Nursing Charles Buckley, CCG Lead

Agenda Item 7

Gloucestershire Clinical Commissioning Group
(Shadow Board)

17th January 2013

Commissioning for Quality Report – Quarter 2

1.0 Introduction

This Quarter 2 report provides Gloucestershire Clinical Commissioning Group (CCG) with assurance in relation to the three aspects of quality:

- Patient and carer experience
- Patient safety and risk
- Clinical effectiveness

The Commissioning for Quality Group assesses, scrutinises, and triangulates data from a wide range of sources in order to seek assurance in relation to the quality of commissioned services. This report summarises the outcomes from the Commissioning for Quality Group, highlights areas of best practice and high quality, as well as any areas of concern or risk along with evidence of remedial action or plans that are in place.

The paper alo sets out some of the latest guidance and recommendations for CCGs in relation to quality development.

2.0 Clinical Effectiveness

2.1 2012/13 Commissioning for Quality and Innovation (CQUIN) – Quarter 2 Attainment

CCG should note the excellent performance and achievement of these important quality improvement targets across the health economy:

Gloucestershire Hospitals NHS Foundation Trust		
Goal	**Indicators**	**Status**
Venous-thromboembolism (VTE) prevention	VTE risk assessment using UNIFY data	
	Appropriate prophylaxis for patients at risk of VTE	
Patient experience – personal needs	Composite indicator on responsiveness to personal needs	
NHS safety thermometer	Incentivise data collection using NHS Safety Thermometer tool	
Dementia	Case finding	
	Diagnostic assessment	
	Referral for specialist diagnosis	
Sepsis six implementation	100% use of sepsis six care bundle in ED for 75% of patients with severe sepsis	
	100% use of sepsis six care bundle for 50% of all patients in Trust (exc. ED)	
Acute kidney injury (AKI)	60% of patients with AKI flag to receive all elements of AKI bundle within 24 hours.	
Patient experience escalator	Multi-level goals on organisational responsiveness to patient experience	
Supporting clinical change programmes	Promotion of the clinical engagement and system change required to deliver the QIPP programme.	
Oesophageal Doppler/cardiac flow monitoring	Implementation of inter-operative cardiac outflow fluid management method (ODM) by end Q4	
Great Western Ambulance Service NHS Trust		
Goal	**Indicators**	**Status**
Patient experience	Electronic patient feedback system	
	Staff attitudes	
	Effective use of individualised and advanced care plans	
Appropriate	Reduction of incidents with a response	

conveyance	Effective feedback to Primary Care	
NHS number	Use of the NHS number	Partial achievement – on course to meet required end of year outcomes
Implementation of Major Trauma Networks	Staff preparation and performance	
Gloucestershire Care Services		
Goal	**Indicators**	**Status**
Venous-thromboembolism (VTE) prevention	VTE risk assessment	
	Appropriate prophylaxis for patients at risk of VTE	
	Root Cause Analysis on all inpatient VTE or Pulmonary Embolism and reported as SIRI	
Patient experience – personal needs	Maintain the response rate in the local Care Services Community Hospital inpatient survey	
	Maintain or improve on the satisfaction rate based on the 11/12 survey	
NHS safety thermometer	Improve collection of data in relation to pressure ulcers, falls, UTIs and VTE	
Dementia	Case finding	
	Diagnostic assessment	
	Referral for specialist diagnosis	
	Care plan evidence	
Patient experience escalator	Making the organisation a provider of choice for patients	
	Promoting shared decision making	
	Dignity in care	
	Leadership	
Falls prevention and reduction	Falls risk assessment to be commenced within 24hrs in 90% of inpatients 65+. Use of falls flag instigated within 24 hours for those identified at risk	
	MDT intervention in 90% of cases, identified as at high risk of falls, within 3 working days of care plan commencement	

	Referral to relevant services on countywide falls pathway e.g. bone health service, falls clinic, community exercise class - either prior to or on discharge	
	Use of falls profiling to identify higher risk areas	
Maternal mental health pathway	Staff training	
	Ante natal and post natal mental health screening	
	Listening visits	
	Data collection	
End of life care	Use of the Liverpool Care Pathway (LCP)	
	Patients preferred choice for place of care at end of life (GCS will be expected to produce a recovery plan)	Achieved 76% against expected 86%
7 day working	Weekend and Bank Holiday discharge and admission activity	
Single point of clinical access (SPCA)	Increase number of referrals to SPCA from GWAS clinical desk	Awaiting contract board discussion
	Ensure that a joint pathway is available so that a successful outcome is achieved	
2gether NHS Foundation Trust		
Goal	**Indicators**	**Status**
Venous-thromboembolism (VTE) prevention	VTE risk assessment using UNIFY data	
	Appropriate prophylaxis for patients at risk of VTE	
Patient experience	Improvement in positive responses to selected patient survey questions	
	Increasing the number of patients who would recommend the provider to others	
	Evidence of seeking patients views on shared decision making and acting on those views	
	Evidence of Board leadership in relation to patient safety and experience	
NHS safety thermometer	NHS safety thermometer	
	Pilot safety thermometer for mental health and learning disabilities	
Telecare and telehealth support for people with dementia	Staff training	
	Improving access availability	
Improving services	Policy and guidance	

and the outcomes for women with mental ill health during pregnancy and up to one year post birth	2gether community staff training (also open to GPs and midwives)	
	GCS Public Health nursing team training	
Care co-ordination	Management of placements	
Medicines management	Atypical antipsychotic generic prescribing	
	Generic prescribing of acetyl cholinesterase inhibitors	
	Reduction of atypical antipsychotic prescribing in dementia patients – formulary compliance 3a	
	Reduction of atypical antipsychotic prescribing in dementia patients – formulary compliance 3b	
Falls prevention	Staff training	
	Audit against falls pathway	
Outcome measurement tool for learning disability services	Outcome measurement tool for learning disability services	

2.2 CQUIN 2013/14 Guidance

Following the publication of "*Everyone Counts: Planning for Patients 2013/14"* in December 2012, the Department of Health (DH) has recently published draft guidance on the framework and expectations for the CQUIN process during 2013/14. A final version is due to be published in February 2013 but the DH does not anticipate any substantive changes to this framework.

The CQUIN financial framework for 2013/14 remains unchanged and is set at a level of 2.5% value for all healthcare services commissioned through the NHS Standard Contract. One fifth (0.5%) of the overall contract value is to be linked to the national CQUIN goals, where these apply. CQUIN monies remain non-recurrent and will be used to incentivise providers to deliver quality and innovation improvements above the baseline requirements set out in the Standard Contract. Commissioners will set challenging but realistic CQUIN schemes for providers, so that there is an expectation that a high proportion of

commissioner CQUIN funding will be earned by providers.

2.2.1 Pre-Qualification Criteria

From April 2013 it is expected that providers will also be compliant with the high impact innovations as described in *"Innovation Health and Wealth, Accelerating Adoption and Diffusion in the NHS"* published by the DH in 2012. This is a change to the current framework and providers will need to have put in place measures to meet at least half of the criteria in order to qualify for the release of any 2013/14 CQUIN funding. The DH has specified which of the criteria apply to each provider type; all criteria are applicable to acute providers but others are variable with provider type.

Pre-qualification criteria are:

1. Increased use of telehealth and telecare
2. Inter-operative fluid management
3. Child in a chair in a day
4. International and commercial activity. Academic Health Science Network.
5. Digital first – reducing inappropriate face to face contact
6. Carers for people with dementia. Information and support.

The majority of these criteria have already been considered during 2012/13 with our providers and some currently operate within CQUIN and QIPP frameworks. Discussions have begun with providers to agree plans for pre-qualification criteria.

2.2.2 National Mandated CQUINS

There are four national CQUIN goals for 2013/14:

1. *Friends and Family Test*- new for 2012/13 and replaces the current inpatient survey-based goal. Further information is contained elsewhere within this report.
2. *NHS Safety Thermometer*. Continuation of existing CQUIN with emphasis on establishing robust data systems and setting local targets to reduction in harm from pressure ulcers, falls and urinary tract infections.
3. *Dementia Care*. Continuation on existing CQUIN with added emphasis on dementia carer support.
4. *VTE.* Continuation of existing CQUIN.

The DH has specified which of the national goals are applicable to provider type (with all applicable to acute providers).

2.2.3 Locally Developed CQUINs

Discussions are ongoing with providers as part of the 2013/14 contract negotiations regarding the development of local CQUIN goals for 2013/14. The locally developed Patient Experience Escalator, which began in 2012/13 as a way of recognising provider organisational approach to patient engagement and experience, will continue across all providers into 2013/14. A number of other local goals will continue where there has been a commitment to support a quality improvement programme over a two year period to ensure that the improvement is fully embedded. Examples include End of Life Care and reduction in Falls within Gloucestershire Care Services; and, identification and management of severe sepsis and acute kidney injury at GHNHSFT. 2gether are committed to further developing the Learning Disability outcome framework and with the merger of GWAS/SWAST there has been discussion to acknowledge there may be schemes common across the patch to develop.

A number of ideas for new goals have been put forward by both commissioning leads and providers and are currently being considered for inclusion into schemes. Discussions are also ongoing as to how the CQUIN schemes can best support the strategic priorities of the CCG and Quality Premium areas.

For further information: www.commissioningboard.nhs.uk/2012/12/cquin-guidance

"*Everyone Counts: Planning for Patients 2013/14*" also includes further detail on the expectations for local delivery of the CCG Indicators Set within the NHS Outcomes Framework. The CCG is already familiar with these publications and further information can be found at www.commissioningboard.nhs.uk/everyonecounts

2.3 Great Western Ambulance Service NHS Trust (GWAS)

GWAS consistently sits within the top decile of the Ambulance Quality Indicator (AQI) national performance data, against each of the 25 System and Clinical Outcome Indicators.

The area which does not consistently achieve the target is the Stroke 60 bundle, for which GWAS has produced robust plans to improve performance.

GWAS will be acquired by South West Ambulance Service NHS Trust (SWAST) in February 2013 and a regular review of performance will continue to ensure sustained high performance. GWAS currently provide daily and monthly performance summaries; NHS Gloucestershire (NHSG) has the national standard contract with GWAS for 2012/13 and the expectation is that this will continue until the end of this financial year. The Performance team will continue to monitor performance in the same manner and continue to report to both the CCG and NHSG Board as required.

2.4 2gether NHS Foundation Trust

Overall, there are no quality concerns for this provider. This quarter we saw a rise in reporting for Serious Incidents (SIs) on the same period compared to previous years. There is no theme of a particular type of incident, although there is an increase in 'attempted suicide' and 'suicide' but this is consistently lower than last year and full investigations are carried out.

As a route to gaining further assurance we have arranged with 2gether a series of joint 'quality' walkabouts (commissioner/provider) to various locations, such as inpatient wards at Wotton Lawn, which commenced in January 2013. The outcomes of these visits will be discussed at the Clinical Quality Review Group (CQRG) and the information gained fed into quality assurance systems.

2.5 Care Quality Commission Quality and Risk Profiles

The Quality and Risk Profile (QRP) is a tool used by the Care Quality Commission (CQC) to gather key information about provider organisations to support the monitoring of compliance against the essential standards of quality and safety. The QRP helps CQC compliance inspectors to assess where risks lie and may prompt front line regulatory activity, such as further enquiries and site visits.

QRPs are also an important tool for providers and commissioners – both to support continuous monitoring of compliance, by ensuring that everyone is working from the same information, and to improve how care is provided and commissioned.

QRPs for GHNHSFT, 2gether and GWAS are now regularly reviewed by the Clinical Quality Review Groups which meet bi-monthly.

2.6 Primary Care

There have been great strides in recent years in improving clinical outcomes in primary care, and there are already quality standards and surveillance through core contracts, enhanced services and Quality Outcome Frameworks.

We plan to work in partnership with the National Commissioning Board's Local Area Team to further review and jointly improve performance and reduce unwarranted variation and there are further opportunities for quality development in primary care through new guidance such as quality premiums for the whole health economy such as through the health and well being indicators.

CCGs have a statutory duty in relation to the quality of primary care and the CfQG have been giving some thought to how we effectively and productively engage with independent contractors in relation to quality developments and to develop robust measures in relation to quality assurance.

The next quarterly report will include a detailed review of quality in the Primary Care contractor setting. Information provided in the update will include:

- GPs – Quality and Outcome Framework, Contract Framework returns, audit programme, patient satisfaction, Dispensing Quality Scheme
- Dentists – Performance Indicators, audit programme, Contract Framework returns
- Opticians – Contract Framework returns
- Pharmacies – Dispensing Quality Scheme, Contract Framework returns

3.0 Patient and Carer Experience

3.1 Patient Experience – 2013/14 CQUIN Update

3.1.1 National CQUINs

0.5% of the value for all healthcare services commissioned through the NHS Standard Contract is to be linked to the national CQUIN goals, where these apply. There are four national CQUIN goals for 2013/14, one of which is the Friends and Family Test.

The question for inpatient services asks "How likely are you to recommend our ward to friends or family if they needed similar care or treatment?".

3.1.2 Friends and Family Test

Goal: To improve the experience of patients in line with Domain 4 of the NHS Outcomes Framework. The Friends and Family Test will provide timely, granular feedback from patients about their experience.

Indicators:

The CQUIN will be structured with three separate elements:

1. 30% of the funding for phased expansion: NHS providers will need to deliver the nationally agreed roll-out plan to the national timetable – maternity by the end of October 2013 and additional services (yet to be defined) by end of March 2014. Missing any element of this will result in non-payment of the CQUIN. NHS South will be piloting the Friends and Family Test in Community Hospitals from April 2013.
2. 40% of the funding for increasing the response rate in the acute inpatient and A&E areas. Achieving a response rate in the top 50%, which also improves on the Q1 response rate.
3. 30% of the funding for increasing the score of the Friends and Family Test question within the 2013/14 staff survey compared with 2012/13 survey results.

Data Source:

1. Two one-off returns from providers to local commissioners on the position at end of October 2013 and March 2014.
2. Providers of NHS funded services will provide monthly data on Friends and Family Test results through the UNIFY central data

collection system.

3. Annual Staff Survey.

Next Steps for Providers and Commissioners:
Acute hospital providers will need to ensure that they can provide Friends and Family scores from 1 April 2013 at the latest that meets the national guidance.

Commissioners and providers will need to put in place implementation plans for rolling out the Friends and Family Test to other areas during 2013/14. The NHS Commissioning Board will publish a national programme, but the first roll-out is for maternity services by October 2013.

Supporting Information:
National Friends and Family Guidance published by the Department of Health is available at http://www.dh.gov.uk/health/2012/10/guidance-nhs-fft/

3.1.3 Gloucestershire Readiness for the Friends and Family Test

NHS Gloucestershire required main providers to consider the implementation of the Friends and Family Test (also known as Net Promoter) in 2012/13 Patient Experience Escalator CQUINs (see below). All required main NHS and independent providers are on track to implement the Friends and Family Test from 1 April 2013, including Gloucestershire Care services.

3.1.4 Local Experience CQUINs

In 2012/13, NHS Gloucestershire introduced the Patient Experience Escalator CQUIN for all main providers. The purpose of the Patient Experience Escalator CQUIN is to embed further the use of patient/carer experience in the improvement of care and service delivery across all NHS organisations within the Gloucestershire health care community (commenced 2012/13). This framework, developed in collaboration between NHS Gloucestershire as commissioner of services and Gloucestershire's provider organisations, sets out 'escalating' levels of challenges for providers of NHS services. An example of the Gloucestershire Hospitals NHS Foundation Trust CQUIN for 2012/13 is in Box 1 below.

Box 1: Gloucestershire Hospitals NHS Foundation Trust agreed 2012/13 Patient Experience Escalator CQUIN

The First 'Escalator' Level focusses on assurance that the systems for the collection and sharing of patients' and carers' experiences is robust e.g. widening the opportunities for feedback on experience. Evidence required: website development, working in partnership with patient support organisations providing support to patients with specific needs, such as visual impairment, the use of patient/carer stories to illustrate learning from experience reported in Quality Account.

The Second 'Escalator' Level seeks to explore how the use of the 'Net Promoter / Family and Friends' question could be obtained and used effectively to improve the experiences of patients across the organisation in 2013/14. Evidence required: description of exploratory work and outcome.

The Third 'Escalator' Level seeks to promote shared decision making through increased involvement of patients and carers in decisions about care and discharge from hospital. Evidence required: Clear processes by which information sharing on decisions on care and treatment is improved between (i) staff, between (ii) patients and staff and between (iii) carers and staff, includes the used of patient and carer stories to illustrate shared decision making reported in Quality Account.

The Fourth 'Escalator' Level focusses on attitudes of staff. Staff attitudes influence the experiences of patients, carers and colleagues. This level builds on excellent work undertaken by the Trust in developing 'Kindness and Respect Behaviour Standards'. Evidence required: the promotion of the 'Kindness and Respect Behaviour Standards' across the organisation, including incorporation into staff appraisals, staff performance management, embedding into staff essential / specific targeted bespoke training and celebrated through the monthly nomination of staff for 'Kindness and Respect Awards'.

The Fifth and final 'Escalator' Level relates to leadership of the organisation demonstrated by a clear commitment from Board to Ward to improve patient, carer and staff experience, based on the knowledge that leaders' attitudes influence the experiences of patients, carers and staff. This level requires a demonstration of an organisational culture which is responsive to patient, carers and staff experience feedback. Evidence required includes outcomes of 'observational audits' undertaken by managers relating to 'Kindness and Respect Behaviour Standards' witnessed in practice, regular Executive visits to wards and

departments consistently demonstrating discussions regarding patient/carer experiences, and patient/carer stories presented in person (if agreed) to the Trust Board.

3.1.5 Local 2012/13 CQUIN Delivery Performance

All main providers are on track at Q2 with Patient Experience Escalator CQUIN evidence.

3.1.6 Local 2013/14 Patient Experience Escalator CQUIN Development

All main providers have met with NHSG commissioners to discuss development of the Patient Experience Escalator CQUIN for 2013/14. Providers will focus on building upon the developments from last year's CQUIN, using evidence collected in 2012/13 to identify areas for focus in 2013/14.

3.2 CQC Patient Survey

Accident and Emergency Department Survey 2012 - Published December 2012

The fourth national survey of accident and emergency patients involved 147 acute and specialist NHS trusts with a major accident and emergency department. The survey contacted eligible patients who had attended A&E departments between January-March 2012. The survey asked 44 questions on a range of sections from ambulance transport, reception and waiting, care and treatment, tests and hospital environment and facilities. It was part of a wider programme of NHS patient surveys which covers a range of topics including mental health, adult inpatients and adult outpatients.

In Gloucestershire 332 patients who had attended GHNHSFT A&E departments took part in the survey, a response rate of 40%. A full report on the survey will be presented to the January 2013 GHNHSFT CQRG meeting and to the Unscheduled Care programme Group.

Our initial review indicates that GHNHSFT results compared well against the average in hospital environment and facilities, initial wait times, ambulance and A&E staff working well together and in the patients overall view on experience (treated with dignity and respect). Further improvements were identified as possible in areas relating to availability of test results prior to leaving the department, patients feeling that

doctors/nurses discussed their anxieties with them and hospital staff informing patients who to contact if there were worried about their condition or treatment after they had left the A&E department.

For further information visit:
www.cqc.org.uk/surveys/accidentandemergency

3.3 National Cancer Patient Experience Programme Survey 2012 - Published August 2012

The second national cancer patient experience survey 2011/12 provides insights into the level of care received by nearly 72,000 inpatient and day case cancer patients. The report of the survey compares performance with the previous 2010 survey and on most questions scores nationally have improved, with the most significant increases in positive scores seen on information and communication issues. There were 9 new questions in this year's survey, including an overarching question asking patients to rate their overall care. This came out with 88% of patients rating their care 'excellent' or 'very good'.

Over 1000 GHNHSFT patients took part in this survey, a response rate of 70% slightly higher than the national rate of 68%.

Overall the percentage of patients attending GHNHSFT who rated their care as excellent was 88% compared with the highest scoring trust at 94%. Within the overall score there was significant variation between specialty areas of between 81% (lung tumour group) to 97% (prostate tumour group). There is variation between tumour groups throughout the survey results. A large number of positive free text comments were received, but less favourable comments related to parking, chemotherapy waiting times, inpatient hospital food and perceived levels of ward staffing.

The survey demonstrated an improvement against the 2010 position in a number of indicators at GHNHSFT including provision of written information, explanation of diagnostic tests and possible side-effects, privacy and dignity, information on home support and clear communication from doctors.

However, GHNHSFT remains in the lowest 20% of trusts for the following areas:

- Patients given written information about the type of cancer they had – 62% vs 86% for highest trust
- Patients given the name of the CNS in charge of their care – 81% vs 99% for highest trust
- Always or nearly always enough nurses on duty – 56% vs 88%
- Hospital staff gave information on getting financial help – 43% vs 77%
- Patient given a choice of treatments – 80% vs 95%
- Hospital staff gave enough emotional support – 66% vs 93%
- Patient waited no longer than 30 minutes for an outpatient appointment – 61% vs 89%
- Patient thought that the Dr spent the right amount of time with them -91% vs 100%
- The GP was given enough information about their care – 91% vs 99%

Findings from the report have been presented to the Cancer Patient Experience Group, a sub group of the Cancer Clinical Programme Group (CPG). An action plan is being developed with the group which will be monitored by the Cancer CPG.

For further the summary report: www.dh.gov.uk/health/2012/08/cancer-experience-survey

For Trust-level reports: www.quality-health.co.uk/2012cancerreports

4.0 Patient Safety and Risk

4.1 Serious Incidents

A total of twenty-two Serious Incidents were reported by the principal provider organisations during the three months ended 30th September 2012. The following paragraphs provide an analysis of these.

4.1.1 Great Western Ambulance Service (GWAS)

As can be seen from the table below, there were four Serious Incidents reported by GWAS during the quarter. This represents a significant decline in comparison with the previous quarter.

Incident Type	11/12 Q3	11/12 Q4	12/13 Q1	12/13 Q2
Response Delay	3	2	4	2
Admin/IT Issue	0	1	0	0
Misdiagnosis	0	2	1	0
Call Classification/Records	0	0	1	1
Inappropriate Advice	0	0	1	0
Suspected Theft	2	0	0	1
Clinical Incident	1	1	1	0
Possible staff contamination	1	0	0	0
Total	**7**	**6**	**8**	**4**

None of the four incidents affected Gloucestershire patients, but were reported to, and investigations were monitored by, NHS Gloucestershire as lead commissioner of ambulance services in the relevant areas.

Investigations into each of these four incidents have been completed and action plans have been agreed to address the concerns identified. Areas covered by the action plans include the reinforcement of GWAS instructions to staff, improved communication processes, the logging and investigation of all mobilisations taking more than fourty-five seconds, enhanced ambulance station security and focused staff training.

4.1.2 2gether NHS Foundation Trust

The six Serious Incidents reported by 2gether during quarter two represent a slight decline in comparison with previous quarters, although no significant trends are apparent.

Incident Type	11/12 Q3	11/12 Q4	12/13 Q1	12/13 Q2
Suspected Suicide	5	2	3	2
Attempted Suicide	1	3	2	1
Unexpected death	1	1	0	1
Violence and aggression	2	1	0	0
Patient Fall	1	0	1	2
Admin/IT issue	0	1	0	0
Illegal act by patient	0	0	1	0
Total	**10**	**8**	**7**	**6**

The four incidents relating to suicides, attempted suicide and unexpected deaths all affected community patients, the two falls related to inpatients at the Charlton Lane Centre.

Comprehensive reports have been received from 2gether management in relation to each of these incidents. The action plans contained within the reports address a number of weaknesses that were identified during the investigation processes. These included the development of the falls care pathway, improvements in record keeping and access, standardisation of documentation, focused staff training, review of the internal referral process and the undertaking of a clinical audit to establish the level of compliance regarding the sharing of care plans with patients and their GPs.

4.1.3 Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT)

As can be seen in the table below, GHNHSFT reported six Serious Incidents during the quarter, including one 'Never Event'.

Incident Type	**11/12 Q3**	**11/12 Q4**	**12/13 Q1**	**12/13 Q2**
C.Diff/Norovirus	1	1	1	1
MRSA	0	0	0	1
Admin/IT Issue	1	1	1	0
Unexpected Death	1	2	1	0
Clinical Incident	2	4	2	2
Pressure Ulcer	2	1	1	1
Legionella	0	0	1	0
Never Event	1	0	0	1
Total	**8**	**9**	**7**	**6**

Never Events are defined as serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. The one Never Event reported by GHNHSFT during the quarter related eye surgery. The two clinical incidents related to a maternity case and an endoscopy procedure.

Investigations have been completed into each of the six Serious Incidents and reports, incorporating action plans, produced. The investigations identified a variety of issues that are being addressed through the action plans. These included issues regarding the

management of waiting lists, use of contractors, antenatal assessments, staff training, development of maternity procedures, equipment availability, assessment and documentation of pressure ulcers, record keeping and the implementation of the WHO (World Health Organisation) cataract checklist.

4.1.4 Gloucestershire Care Services

As can be seen from the table below, Care Services reported six Serious Incidents during quarter two, five of which related to acquired Grade 3 pressure ulcers.

Incident Type	**11/12 Q3**	**11/12 Q4**	**12/13 Q1**	**12/13 Q2**
Pressure Ulcer	9	9	7	5
Admin/IT Issue	0	0	2	0
Unexpected Death	1	3	0	1
Total	**10**	**12**	**9**	**6**

Two of the reported pressure ulcers were found, on investigation, not to meet the criteria for Serious Incidents as it transpired that both had been inherited from the community and patients were not known to the service. The unexpected death related to a community hospital inpatient.

Investigations into the four confirmed Serious Incidents have been completed and action plans compiled to address the issues identified. The principal areas for improvement related to pressure area, wound and nutritional risk assessments, availability of pressure relieving equipment, documentation, staff training and discharge planning.

4.2 Incidents

NHS Gloucestershire encourages all staff and independent contractors to report incidents. Staff and all GP practices are able to report electronically via the 'Datixweb' system. Other independent contractors are able to report via the internet or by a paper based system.

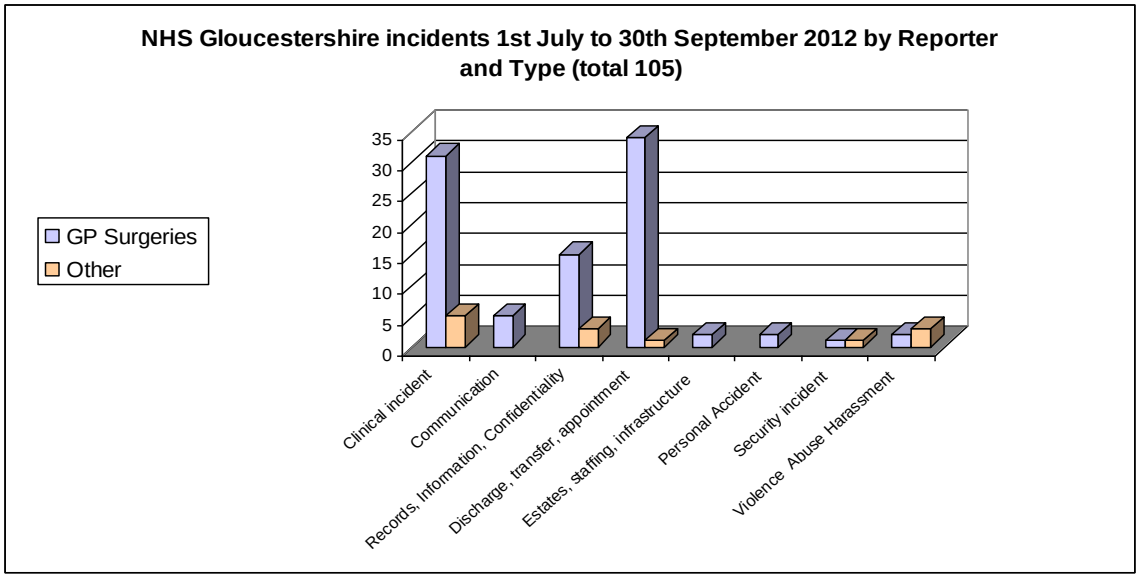
Details of incidents are entered onto the 'Datix' database which is used to provide reports for groups and managers throughout the organisation in order to ensure that any relevant trends are properly considered and that

lessons learned are appropriately shared. Regular reports are sent to the relevant leads and managers on a monthly basis. However, serious issues are flagged to the appropriate managers and providers immediately on submission.

Information regarding common themes and trends arising from the incident reports are shared with the GP community via the e-bulletin.

Many of the incidents reported by GPs relate to problems encountered with services provided by other local NHS providers. Details of these incidents are provided to the relevant organisations and the relevant Clinical Quality Review Group by the Governance Team by way of monthly reports either for investigation (where the incident is considered significant) or information on more minor incidents. This ensures that the issues can be investigated and action taken to prevent re-occurrence.

The graph below provides an analysis of the 105 incidents reported to NHS Gloucestershire during the quarter ended 30th September 2012. Of these, 92 were reported by GP practices and 13 were reported by NHS Gloucestershire employees and other third party contractors. Of the 92 reported by GP practices, 16 were internal to the practices and 76 concerned other providers.



As set out in section 2.6, we plan to further develop and report quality data in realtion to independent contractors.

4.3 Never Events Policy Framework and Thematic Review

An update to the national never events policy was published in October 2012. The policy sets out responsibilities for both providers and commissioners and highlights two additions to the existing list of 25 never events - transplantation of incompatible organs as a result of error and misidentification of patients.

From the national review of the root causes of never events they identified a failure to follow the World Health Organisation (WHO) Safer Surgical checklist procedures as a major contributory factor. Findings from the review have been shared with providers and recommendations discussed.

During 2011/12, GHNHSFT had four never events, of which three related to retention of a foreign object and one related to extraction of the wrong tooth. As previously reported to the Board, following these never events at GHNHSFT a joint review was undertaken with the representatives from the SHA, PCT and acute trust and an action plan implemented during 2011/12 to improve safety for patients undergoing surgical procedures including usage of the WHO Safer Surgical Checklist. The trust has continued to carry out regular observational audits of WHO compliance and performance in this patient safety area has improved significantly. GHNHSFT has reported 1 never event during 2012-13; this never event relates to wrong implant (lens).

There was 1 Never Event reported by a Gloucestershire independent provider during 2011/12 which related to a retained swab post gynaecological procedure.

For more information:
www.dh.gov.uk/2012/10/never-events
“Thematic Review of South of England Never Events 2011-12” published October 2012 by NHS South

5.0 Safeguarding

5.1 Safeguarding Adults

Gloucestershire Safeguarding Adults Board (GSAB) has continued to develop throughout 2012/13, and has gained wider representation from across the partnership through active members who are sufficiently senior in their organisations to influence, lead and support the Board's business and further development.

The Board meets quarterly, and Dr Andrew Seymour has joined as the CCG Board lead.

The Board receives standing items for review relating to:

- Court of Protection
- Risk Register
- Performance Dashboard

It also receives reports from the subgroups:

- Serious Case Review (SCR)
- Quality and Performance
- Policy and Workforce development
- Communication and Engagement
- Mental Capacity Act/Deprivation of Liberty Standards

5.1.1 Items to Note (Children and Adult Safeguarding)

1. Memorandum of Understanding and Register of Interests

   Currently GSAB has a Memorandum of Understanding, but Gloucestershire Safeguarding Childrens Board (GSCB) does not. Neither Board has a process to register and consider members interests. It was agreed by both Boards in June 2012 to develop a single Constitution and Memorandum of Understanding and Register of Interests for consideration. A draft was circulated and discussed at the December 2012 Board, and members are asked to feedback comments by 15.1.13. The draft builds on the existing Memorandum for GSAB, and provides useful alignment for both Boards.

2. Serious Case Review Meeting in relation to Winterbourne View Investigation

The GSAB held an extra-ordinary meeting to consider the findings and recommendations of the Winterbourne View investigation. There is an action plan in place and each organisation is undertaking any necessary work to ensure all the recommendations are in place within the county. The action plan is monitored by GSAB, and any outstanding issues will form part of the 2012/13 Business Plan.

3. Current national issues

The Safeguarding Board noted a recent letter received from David Nicholson in relation to the developments surrounding investigations into Jimmy Saville. All NHS Trusts and Local Authorities are required to review processes in place relating to Safeguarding.

It was noted that as a result of both the Winterbourne View investigation, and Saville investigation, there is increased national focus on Safeguarding, and also increased local referrals. The Board will be monitoring this closely in relation to:

- Risk and capacity
- Contract requirements and compliance

Gloucestershire County Council Safeguarding team will be subject to a Regional Peer review in May 2013 – all Board members were asked to note as there will be requirements to be engaged in the process.

4. GSAB and GSCB Alignment

There is a Joint Chair of both Boards – this provides an overview of the work of each board. Consideration is being given to maximising alignment and efficiency for both boards. However it is recognised that the duties and responsibilities, whilst similar in some respects, are also different (there are currently no statutory duties for Safeguarding Adults Boards). The Constitution and Memorandum of Understanding is regarded as a positive step to support the work of both Boards.

5.2 Safeguarding Children

NHS Gloucestershire continues in its commitment to safeguard the welfare of children in Gloucestershire through robust commissioning arrangements.

Dr Jeremy Welch has recently been appointed as the lead GP for children's safeguarding for the CCG and sits on the Gloucestershire Local Safeguarding Children's Board (GSCB).

NHS Gloucestershire remains an active partner agency in the GSCB. As part of this commitment, the Designated Nurse has contributed to the Safeguarding Children Institute for Excellence (SCIE) pilot of a new integrated approach to reviewing cases of harm to children. The findings of this pilot are due to be presented to the GSCB in February 2013.

NHS Gloucestershire also took part in a multi- agency audit on the management and awareness of Child Sexual Exploration in Gloucestershire. This audit informed the launch of the Gloucestershire Child Sexual Exploitation strategy in November 2012.

As part of this strategy, and in response to requests from schools, the GSCB funded a powerful interactive theatre production 'Chelsea's Choice' which was rolled out to all Year 8 pupils in Gloucestershire. The programme ran for 4 weeks and was seen by 6000 pupils. 1000 pupils were audited and the results were extremely positive; 98% of the pupils responded that they now knew where to go for help with issues relating to Child Sexual Exploitation which has been demonstrated in the play.

The Designated Nurse also took part in an initiative to go into schools to meet with year 9 pupils to ask them about what 'keeping safe' meant to them and discuss safeguarding issues. The results will be correlated into a report to be presented to the GSCB in April 2013.

Child Protection training remains a challenge, ensuring that there is enough available training available for front line practitioners. The Designated Doctor has trained the GPs in 4 out of the 7 Cluster areas in Gloucestershire with dates to train the remaining clusters in January 2013.

All Serious Case review action plans have been completed and signed off by the GSCB. There are currently no Serious Case Reviews in progress.

6.0 Dr Foster Hospital Guide 2012 - published December 2012

Dr Foster's Annual Guide provides an independent examination of the hospital performance in the UK and offers both health professionals and patients the opportunity to access comparative data on local and national service provision. The 2012 report included new sections regarding elderly care, patient safety at board level and chronic pain.

The Guide uses indicators derived from Secondary Uses Services (SUS) data which are then published at an individual trust level. Indicators used fall into the following broad categories: mortality ratios, efficiency index and clinical variances.

6.1 Efficiency Index

The 2012 Hospital Guide included 13 measures of efficiency and GHNHSFT performed well in the following indicators:

- 28 day emergency readmissions
- 7 day emergency readmissions
- Day case rate (from BADS basket of procedures)
- DNA rate
- Admissions where procedure not performed

But performed worse than expected on:

- Procedures carried out on a weekday

This indicator relates to elective procedures and is linked to the fact that the Trust does not currently perform non-urgent procedures at the weekend. Discussions have been held at the contract board meeting regarding performance of this indicator.

6.2 Mortality Ratios

The guide includes four different measures of hospital mortality:

1. Hospital Standardised Mortality Ratio (HSMR) which measures in-hospital deaths
2. Summary Hospital-level Mortality Indicator (SHMI) which measures deaths in and out of hospital
3. Deaths after surgery, which looks at surgical patients with complications
4. Deaths in low-risk groups, which looks at patients with a very low risk of death

GHNHSFT is within the expected range for mortality ratios. The need to

improve identification and management of patients with severe sepsis and acute kidney injury was identified locally in 2011 as areas of concern and has been supported through the CQUIN process during 2012.

6.3 Clinical Variances

The Trust performed better than expected in two of the indicators:

1. Short-stay emergency admissions for COPD
2. Short stay emergency admissions for UTI

For more information visit www.drfosterhealth.co.uk

7.0 Summary

In summary, through the robust clinical governance arrangements that are in place, and the productive relationships that have been developed with our partners, there continues to be a high degree of scrutiny and assurance sought in relation to the quality of commissioned services.

The team continue to seek opportunites for quality improvement and to refine and review the frameworks and mechanisms we have in place to be able to provide rich data and information to the Commissioning for Quality Group to review, and in order to provide assurance to the CCG Board.

8.0 Recommendation(s)

Gloucestershire Clinical Commissioning Group Shadow Board are invited to note this report.

Gloucestershire Clinical Commissioning Group
(Shadow Board)

Meeting Date	**17th January 2012**
Title	**Performance against Commissioning Report**
Executive Summary	This integrated performance report provi des Gloucestershire Clinical Commissioni ng Group (GCCG) with a stra tegic overview of the financial and servic e performance issues by exception. This report sets out the Financial position is as at the end of November 2012. The Commi ssioned Service Performance position is dependent upon the availability of the data.
Key Issues	These are set out in the main body of the report
Risk Issues: Original Risk Residual Risk	All risks are identified within the relevant sections of this report.
Financial Impact	Not meeting key financial targets
Legal Issues (including NHS Constitution)	Compliance with the NHS Constitution as part of the 18 week referral to treatment commitment
Impact on Equality and Diversity	Not Applicable.
Impact on Health Inequalities	The are no direct health and equality implications contained within this report
Impact on Sustainable Development	The are no direct sustainability implications contained within this report
Patient and Public Involvement	The Health, Community & Care Overvi ew and Scrutiny Committee receive a report of performance against key targets.
Recommendation	The Board is asked to: • Take note of the reported financial position for 2012/13 • Take note of the perform ance against

	national targets and the acti ons taken to ensure that performance i s at a high standard.
Author & Designation	Roy Hewlett, Assistant Director Performance & Planning (NHSG) Steve Perkins, Head of Financial Planning (NHSG)
Sponsoring Director (if not author)	Mary Hutton, Director of Finance

Agenda Item 8

Gloucestershire Clinical Commissioning Group
(Shadow Board)

January 2012

Integrated Performance Report

1 Introduction

1.1 This report sets out NHS Gloucestershi re (NHSG) 2012/13 Financial and Commissioned Service performance. It is broken down into two secti ons covering performance relating to the key commissioning service targets and financial position of NHSG.

1.3 Only those areas of pe rformance assessed as being at significant risk of failure at year end, or other issues that engendered concerns throughout the year, for which the Board need to be made aware of, are included in the report. Where standards are reported on a quarterl y basis, the board will be informed of updates as and w hen data is availabl e or new information comes to light.

The full summary of performanc e i s included in the relevant appendices.

1.4 The supporting appendices provide a full analysis of the PCT's Finance positi on, and performance against our Commissioni ng performance targets. The 2012/13 commissi oning performance scorecard (appendix 3) provides an i ntegrated report descri bing the performance of NHSG. The scorecard covers the 2012/13 Operating Framework targets, NHS Constitution commitments and key 'local offer' commitments.

2 Performance

2.1 A full overview of current performance of N HSG against the national and key local targets is gi ven in appendi x 3 that is ordered in the following overarching themes;

- Unscheduled Care
- Planned care
- Primary and Community Care
- Public Health
- Mental Health and Learning Disabilities
- Quality

All indicators are RAG rated, based on the *2012/13 NHS Performance Framework* thresholds. In addition, the Year To Date and Year End Forecast positions are also given to enable the level of risk to better quantified at year end.

2.2 The overall level of performance is very good and a summary of the YTD position is given in the table below. This shows that of the total of 50 indicators reported on; 41 were rated Green (82%), 9 Amber (18%) and no Red (0%).

Breakdown of current year to date performance by RAG status of indicator			
	Green	Amber	Red
NHS Gloucestershire	41	9	0

Percentage	82%	18%	0%

2.3 Areas where performance has been particularly good include:

- The 4 hour A&E target is being met by all hospitals in the PCT area.
- Both Cat A8 and A19 performance targets have been achieved throughout the year.
- Patients are able to receive treatment for Community Services in Gloucestershire within 8 weeks of referral. These are some of the best access times in the country.
- VTE risk assessment target has been consistently met within all Hospitals within the PCT area.

2.4 The table below provides a fuller position statement for all the Amber and Red rated indicators. This table outlines current performance, identifies the issues leading to that performance and mitigating actions being taken to recover performance.

Ref	PCT	Indicator	Status	Issue	Mitigating Action
Planned Care					
PHQ19 NHS	Glos	At least 90% of Trauma & Orthopaedic admitted RTT pathways should be treated within 18 Weeks	**AMBER YTD** There has been significant improvement in performance over recent months and the standard was achieved in November, NHSG (92.3%) and GHNHSFT (90.8%). Year to date performance has improved from 84.5% in October to 85.5% at the end of December and as a result is now rated just	Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) has had a persistent backlog of T&O patients who had already waited more than 18 weeks. This backlog has been significantly reduced and is now one of the lowest in the South of England. November performance represents the first time this standard has been achieved in T&O. NHSG is expecting this standard to be	GHNHSFT have fulfilled their commitment to achieve the target by the end of Q3 2012/13 and have actually achieved the target a month earlier than planned. GHNHSFT will continue to: •Increase trauma lists to reduce cancellation of elective lists •Minimise medical outliers utilising Orthopaedic wards Consultants with the longest waits will still have their job plans altered to ensure that their patients can been seen within 18

Ref	PCT	Indicator	Status	Issue	Mitigating Action
			amber.	attained in December, and sustained throughout the remainder of the year.	weeks. New Referrals into Orthopaedics have reduced by 17% at month 6 which will help with GHNHSFT capacity pressures.
PHQ22 NHS	Glos	Not more than 1% of patients should have waited more than 6 weeks for one of the 15 key diagnostic tests	**AMBER YTD** Only 0.3% of patients at the end of November had waited 6 weeks or more (3.7% YTD). This represents 20 breaches of which 9 were at GHNHSFT, 5 at both UHBT and Oxrad, 1 at NBT	GHNHSFT have not had sufficient endoscopy capacity to meet demand and clear the waiting list backlog. The situation worsened following the departure of a locum and Clinical Fellow.	GHNHSFT have cleared the backlog and attained the target as in line with their recovery action plan. GHNHSFT have extended the contract of a locum for a further six-months and increased weekend lists, this additional activity has been ring-fenced for over 6 week waiters. Focus is now on reducing the backlog of surveillance and planned patients

Ref	PCT	Indicator	Status	Issue	Mitigating Action
			This is the first month that the target has been achieved in 2012/13 and it is forecast that the target will be achieved in December and for the remainder of the year.		utilising the locums in post solely for this purpose as well as adding patients to regular lists. The NHSG performance lead is meeting with the GHNHSFT Service lead fortnightly to monitor progress.
PHQ24	NHS Glos	At least 93% of patients should be seen within 2 weeks of an urgent referral for suspected cancer	**AMBER YTD** 90.7% YTD but the target has been achieved in the last two months, September (93.1%) and October (93.8%). The target is also forecast to be	Performance has been impacted by an increase of over 10% in 2 week referrals in the first 8 months of 2012/13 compared to the same period the previous year. Additionally many of the breaches are due to patients choosing to wait longer than 2 weeks.	NHSG expects performance to be attained throughout the remainder of 2012/13. GHNHSFT are ensuring that patients are offered an appointment as early as possible in the 2 week period to reduce the number of patient choice breaches.

Ref	PCT	Indicator	Status	Issue	Mitigating Action
			achieved in November and December.	Lack of endoscopy capacity had also led to patients having to wait longer than 2 weeks.	GHNHSFT has attained the standard in October and are forecasting that the standard will also be achieved in November and December.
PHQ03	NHS Glos	At least 85% of patients receiving first definitive treatment for cancer should be seen within 62 days from an Urgent GP referral	**AMBER YTD** 81.2% in October 83.1% YTD	Main reason for underperformance has been patients not having all diagnostic tests in time. Urology has been the specialty which has seen the majority of breaches. Urology breaches have been significantly reduced in November and December and this target is forecast to be met in Quarter 3	GHNHSFT have submitted an action plan, primarily around addressing Urology breaches, which accounts for the majority of the breaches, with the following actions: - Increase theatre capacity (inc. evening & weekend sessions) - Review of clinical staffing rotas - Employment of a Consultant and Clinical Fellow As a result of the action

Ref	PCT	Indicator	Status	Issue	Mitigating Action
					plan Urology breaches have significantly reduced in October and November to date and GHNHSFT forecast that the target will be achieved in both of the last 2 quarters of the year.
Public Health					
Improving Access to Psychological Therapies (IAPT)					
PHQ13_5	NHS Glos	The proportion of people who have depression and/or anxiety disorders who receive psychological therapies	**AMBER YTD** 3.8% at Q2 against a plan of 4.5%	This target was achieved in 2011/12 however 2gether NHS Foundation performance in Q1 was significantly below expected levels.	Following a formal performance meeting an action Plan has been received from 2gNHSFT which includes: - Working closely with Prison Health - Increasing referrals into the service - Streamlining initial assessments by making this part of their referral process - Training of health visitors to support
PHQ13_6	NHS Glos	The proportion of people who complete therapy who are moving towards recovery	**AMBER YTD** 47.8% at Q2 against a plan of 51.9%		

Ref	PCT	Indicator	Status	Issue	Mitigating Action
					delivery We are confident that the target will be achieved at year end and there has already been a significant improvement in Q2 performance.
Quality					
PHQ27	NHS Glos	Number of MRSA Infections (Health Community)	**AMBER YTD** 7 against a target of 4	The target set for 2012/13 represents a 60% reduction on the 21011/12 outturn. This was always going to be challenging target to achieve. Increased emergency admissions and a bout of Norovirus affecting the hospitals winter bed state has increased	NHSG undertakes a RCA (Root Cause Analysis) of each case to determine any trends and links with other health communities to review best practice.
		Number of MRSA Infections post-48 hours (Acute Trust)	**AMBER YTD** 6 against a target of 4		

Ref	PCT	Indicator	Status	Issue	Mitigating Action
				testing which may well affect GHNHSFTs ability to remain within the ceiling limit	
PHQ28 NHS	Glos	Number of C.Diff infections (Health Community)	**AMBER YTD** 14 against target of 11 in November (this represents just 3 cases per 100k of the Gloucestershire population) YTD 40 over Plan	Performance has improved compared to 21 in October '12. No specific themes can be identified to account for the increase; however similar levels of increases have been experienced in other health communities, throughout the South West. A bout of Norovirus in November has increased the level of testing and also affected the bed	Short life working group has been established to look at incidences' particularly in the GP Practices (Community). Along with the Countywide Healthcare Associated Infection Strategy group, this will have a strong clinical focus with a NHSG lead GP and NHSG Head of Medicines Management attending both groups NHSG also attend GHNHSFT antibiotic prescribing group to ensure consistent approach to tackling this

Ref	PCT	Indicator	Status	Issue	Mitigating Action
				state which will impact the ability to remain within the monthly ceiling limit.	standard throughout the county.

4.0 NHS Gloucestershire Financial Overview 2012/13

4.1 NHS Gloucestershire (NHSG) has planned to deliver a surplus of £8.9m for the year 2012/13 against an anticipated revenue resource limit of £962.4m. Appendix 1 shows the income and expenditure position for the year. Appendix 2 illustrates the position for expenditure and outturn variance.

4.2 The income and expenditure year to date position at 31st October 2012 is a surplus of £5.2m. This is in line with the planned year end position of £8.9m surplus. Table 1 below identifies the key variances at Month 07:

Programme area	Forecast Outturn Variance £'m
Healthcare Providers	(11.6)
Primary Care & Prescribing	0.5
Admin & Provisions	0.0
Reserves	20.0
Total	8.9

4.3 Gloucestershire Hospitals NHSFT – Contract overview

4.4 The Month 8 year to date position is £6.9m overspent (£5.2m at month 7). GHFT data available at month 8 reporting is complete up to month 7. The following report is based on extrapolation of the month 7 data.

4.5 A contract forecast outturn overspend of £9.9m (£8.1m at month 7) is reported. The movement mostly relates to reduced expected future month benefit from QIPP schemes and inclusion of additional CQUIN payment within the forecast. Additional Electi ve T&O costs have also been included at month 8 however these costs have been met by an earmarked reserve.

Finance Section - exceptions based on significant overspend variances in the NHSG outturn variance

(Sign convention – a positive value indicates an underspend, negative (-) value indicates an overspend)

Budget area	YTD Variance	Forecast Variance	Issue / Financial Risk	Mitigating Actions
Planned Care				
GHNHSFT contract – Excluded Drugs	-£0.5m	-£0.7m	Excluded drugs expenditure to date is 7% above plan at Month 7. A contract risk share is applied resulting in 3.5% of pressure against contract.	Drugs indicated as increased are Cytokline modulators, Drugs affecting immune response and Immunomodulating drugs.
Unscheduled Care				
GHNHSFT contract – Emergency admissions	-£4.8m	-£7.5m	During the first 4 months of 2012/13 emergency admission levels were above both the contract plan and the levels seen in 11/12.The current forecast overspend maintains the assumption that this variance is expected to stabilise in line with plan	It has been identified that a significant proportion of the increase in admissions is in relation to patients under age 9 with the prime diagnosis of infectious diseases and patients over age 80 with diseases of the respiratory system.

Budget area	YTD Variance	Forecast Variance	Issue / Financial Risk	Mitigating Actions
			from month 6. Latest contract monitoring continues to support this position as most likely. The forecast £7.5m overspend includes within it £3.4m of pressure resulting from QIPP planned delivery requirement.	Working groups have been set up to look at the Paediatric increases. These groups include Public Health and Commissioning colleagues with an aim to establish the root causes of the increase seen in the early part of the year.
GHNHSFT contract – Maternity/other Non-Elective admissions	-£0.7m	-£1.1m	Increased Obstetric admissions trend above planned levels	Indication is that the numbers of births have not significantly increased but complexity of births (e.g. increased c-sections) and levels of non-delivery admissions have increased resulting in this variance.
Other Contractual				
GHNHSFT contract – QIPP	-£3.8m	-£5.0m	The reported forecast position currently includes	Planned Care and Unscheduled Care

Budget area	YTD Variance	Forecast Variance	Issue / Financial Risk	Mitigating Actions
delivery			£5.8m of the £12.3m QIPP requirement as 'assumed' contract benefit. However, in addition to the assumed QIPP benefit, £1.4m of Emergency threshold adjustment has also been accounted for within the reported contract position. As a result £5.0m lower delivery than the contract plan is reported. The original planned benefit was profiled as being delivered later in the financial year. Overall scheme delivery is reviewed each month.	programme leads will be reviewing each scheme delivery assumption and potential for additional schemes on an ongoing basis.
In County-Tetbury	-£0.2m	-£0.3m	At month 8 Tetbury is Overspent by £0.2m, part is due to budget planning pressure and the rest is over	

Budget area	YTD Variance	Forecast Variance	Issue / Financial Risk	Mitigating Actions
			activity in MIU, Outpatients and Day surgery within the following specialties:- Ophthalmology, Gynaecology, and Maxillo facial/ Dermatology.	
Winfield	-£0.2m	-£0.2m	This overspend is in relation to unexpected 11/12 charge that has been incurred in 12/13.	
Out Of County Contracts	-£0.5m	-£0.9m	NBT are reporting a year to date overspend of -£0.5m based on month 6 data. Non elective activity is overperforming by -£0.2m in general medicine, T&O and urology while the disabled services are overperforming by £0.1m ytd.	Investigation of cardiac elective and non elective activity across specialised and non specialised contracts to test coding
	-£0.2m	-£0.3m	UHBT report year to date overspend of -£0.2m based on 7 months data. --£0.2m	

Budget area	YTD Variance	Forecast Variance	Issue / Financial Risk	Mitigating Actions
			overspend relates non-elective cardiac surgery and cardiology, and -£0.1m on associated critical care and excluded drugs. Partially offset by £0.2m underspend in elective cardiac and thoracic activity.	
	-£0.4m	-£0.7m	Oxford University Hospitals are forecasting an overspend of -£0.7m based on month 7 activity. Cardiology is overperforming by -£0.4m across electives, non electives and devices. Non elective T&O at Oxford Radcliffe is also overperforming by -£0.1m.	
	-£0.4m	-£0.7m	Elsewhere, Great Western forecasts an overspend of -£0.7m on elective T&O, non elective general medicine and T&O as well as PBR	

Budget area	YTD Variance	Forecast Variance	Issue / Financial Risk	Mitigating Actions
			excluded devices. All other direct OOC contracts are performing broadly to plan.	
Specialist Commissioning				
Specialised Commissioning	-£1.0m	-£1.5m	Forecast overspend of -£0.4m based on month 6 data. This is made up of a forecast underspend of £1.3m on mental health (low secure), and a forecast overspend of -£1.7m on acute care. The acute position has seen an improvement of £0.7m against UHBT across BMT's, paediatric nephrology and paediatric cardiac surgery. Significant forecast overperformance:	Have met with SWSCG and highlighted some areas of overperformance and straightline forecasting for investigation. These include cardiac, BMT and the Bristol and GHT contracts. Detail is being sent by SWSCG in relation to QIPP delivery on repatriation and renal.

Budget area	YTD Variance	Forecast Variance	Issue / Financial Risk	Mitigating Actions
			UHBT -£1.2m (-£1.9m last month). Cardiac surgery and congenital heart disease -£0.4m, BMTs forecast overspend of -£0.9m. Oxford -£0.5m (-£0.7m last month). Cardiac surgery (£0.2m improvement in forecast) and neurosurgery. Birmingham Children's Hospital -£0.3m. Predominantly due to a high cost paediatric gastroenterology patient. Great Ormond Street -£0.4m. High cost CAMHS patient and a patient receiving cardiac surgery.	

Budget area	YTD Variance	Forecast Variance	Issue / Financial Risk	Mitigating Actions
			Other significant movements: North Bristol improvement of £0.3m, and Royal Orthopaedic deterioration of £0.3m. GHT's forecast underspend of £0.9m (£0.7m last month), against morbid obesity, radiotherapy and other areas.	
Non Acute				
Continuing Healthcare (CHC)	£2.0m	£3.0m	As at month 8, low placement numbers and associated costs continue to indicate a significant forecast under spend. CHC budgets were reduced by £2.2m for 12/13 due to significant QIPP achievement in 11/12. The £3.0m forecast under spend is against this rebased budget.	Continual close monitoring in conjunction with Funded Nursing Care placement numbers and costs, which are likely to rise as CHC costs fall. At present however, there is only a small YTD overspend reported against FNC.
Funded Nursing	-£0.32m	-£0.50m	Reduction in CHC eligibility	See above (CHC)

Budget area	YTD Variance	Forecast Variance	Issue / Financial Risk	Mitigating Actions
Care (FNC)			has led to increased pressure on FNC budget. No significant change in position from month 7	
Mental Health	-£0.62m	-£0.95m	There are currently a large number of Eating Disorder (ED) placements in out of county placements, if this number continues the financial pressure on the ED budgets could rise.	Ongoing placement reviews in ED.
Learning Disabilities	-£0.14m	-£0.2m	Forecasted pressure around ability to achieve full £1.5m QIPP target for 12/13	Discussions around additional Social Transfer related funding are taking place in hope of mitigating risk of pressure in this area.
Acquired Brain Injury	£0.2m	£0.3m	1 Placement remains in the service and is likely to remain in for the remainder of the year. If additional placements require ABI treatment this will decrease	

Budget area	YTD Variance	Forecast Variance	Issue / Financial Risk	Mitigating Actions
			the forecast underspend	
Primary care				
Community Pharmacy	-£0.45m	-£1.15m	Overspend relates to previous year cost pressure. Pattern of spend from previous years indicates claims will be higher as the year progresses.	Ongoing monitoring and liaising with medicines management team
Dental	£1.0m	£2.36m	Dental Budget continues to under spend against budget. Higher dental income in month 4 contributing to higher under spend in month.	Ongoing monitoring and liaising with Primary care team.

5 Recommendations

5.1 The Board is asked to:

- **Take note of the reported financial position for 2012/13**
- **Take note of the performance against national targets and the actions taken to ensure that performance is at a high standard.**
- **Take note of the performance against the key deliverables in the Annual Operating Plan and the actions taken to ensure that performance is at a high standard.**

6 Appendices

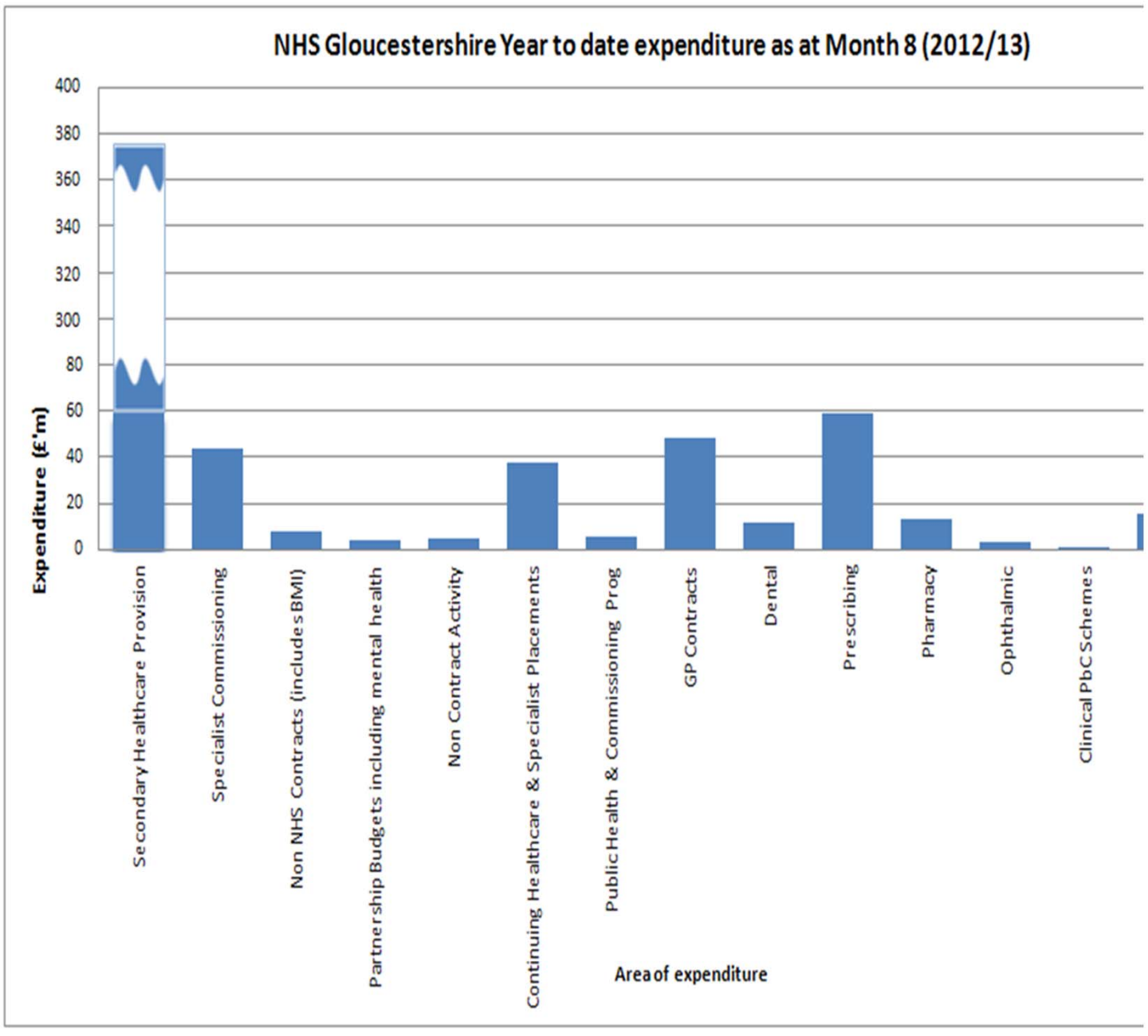
6.1 Appendix 1: NHSG Income and expenditure position for 2012/13 as at month 8
Appendix 2: NHSG Year to date expenditure and Outturn variance at month 8
Appendix 3: NHSG Integrated Performance Scorecard
Appendix 4: NHSG Capital programme 2012/13 at month 8
Appendix 5: NHSG Better Payment Practice Code
Appendix 6: NHSG Cash Reconciliation
Appendix 7: NHSG Balance Sheet

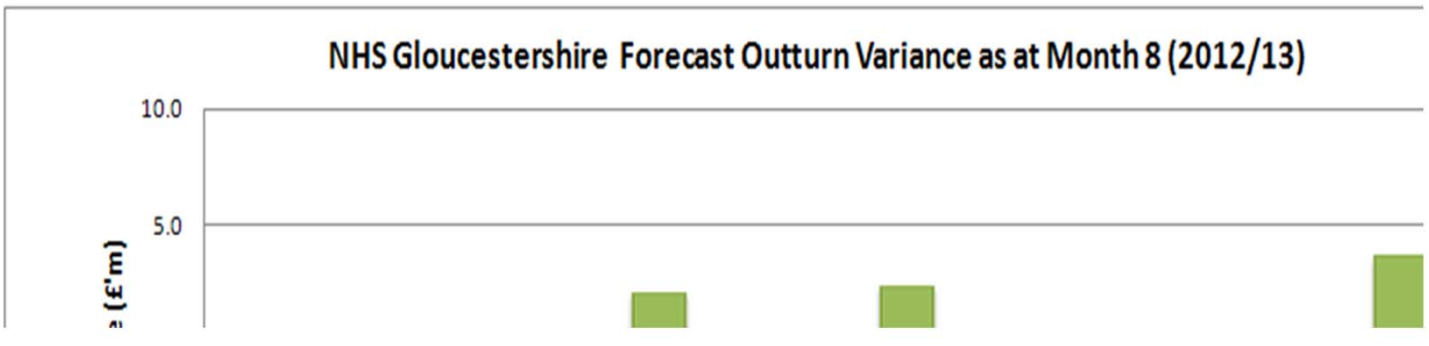
Gloucestershire Swindon

Appendix 1 - NHSG Financial Performance Report 2012/13 - Summary Financial Information to November 2012 (M08)

	Year to Date Position			Forecast Outturn					Previous Month Forecast Outturn Variance	Status
	Budget £'m	Actual £'m	Variance £'m	Recurrent Budget £'m	Non-recurrent Budget £m	Total Budget £m	Actual £'m	Variance £'m	(Adverse) / Favourable £'m	Trend
Resource Limit (notified)				902.7	45.7	948.4	939.5	8.9		
Anticipated Allocations				0.0	14.0	14.0	14.0	0.0		
Revenue Resource Limit	**626.2**	**620.2**	**6.0**	**902.7**	**59.7**	**962.4**	**953.5**	**8.9**		
Revenue Expenditure										
Health Care Providers:										
Secondary Health Care Providers	357.3	365.9	(8.6)	515.6	18.4	534.0	546.6	(12.6)	(10.3)	↓
Specialist Commissioning	43.5	43.8	(0.3)	68.7	(3.1)	65.6	66.0	(0.4)	(1.2)	↑
Non NHS Contracts (includes BMI)	7.6	7.9	(0.3)	11.8	0.1	11.8	11.9	(0.0)	(0.0)	↔
Partnership Budgets including mental health	4.1	3.9	0.2	3.5	2.6	6.1	6.1	0.0	(0.2)	↑
Non-contracted Activity	3.9	4.4	(0.5)	6.3	(0.4)	5.9	6.6	(0.7)	(0.7)	↔
Continuing Health Care & Specialist Placements	38.9	37.7	1.2	48.3	8.9	57.2	55.1	2.1	2.0	↑
Public health & Commissioning programmes	5.4	5.7	(0.3)	4.6	3.1	7.7	7.7	0.0	0.0	↔
Sub-total	460.7	469.5	(8.8)	658.8	29.5	688.3	699.9	(11.6)	(10.5)	↓
Primary Care:										
GP Contracts	48.9	48.5	0.4	76.2	1.9	78.1	78.3	(0.2)	(0.3)	↑
Dental Services	13.1	11.3	1.8	(2.0)	21.7	19.7	17.4	2.3	2.3	↔
Prescribing including GP prescribing	58.4	58.7	(0.3)	87.5	0.0	87.5	88.0	(0.5)	(0.5)	↔
Pharmacy	12.5	13.1	(0.6)	11.2	7.6	18.8	19.9	(1.2)	(1.2)	↔
Ophthalmic Services	3.5	3.3	0.2	0.6	4.7	5.3	5.1	0.3	0.3	↔
Clinical PBC Schemes	0.8	0.3	0.5	1.1	0.0	1.1	1.3	(0.2)	(0.2)	↔
Sub-total	137.2	135.2	2.0	174.7	35.9	210.6	210.0	0.5	0.5	↑
Administration & Provisions	15.7	15.8	(0.1)	15.8	5.7	21.5	21.5	0.0	0.0	↔
Reserves	12.6	(0.3)	12.9	53.4	(11.3)	42.1	22.0	20.0	18.9	↑
Sub-total	28.3	15.5	12.8	69.2	(5.7)	63.5	43.5	20.0	18.9	↑
Total PCT Revenue Expenditure	**626.2**	**620.2**	**6.0**	**902.7**	**59.7**	**962.4**	**953.5**	**8.9**	**8.9**	↔
Surplus	**626.2**	**620.2**	**6.0**	**902.7**	**59.7**	**962.4**	**953.5**	**8.9**	**8.9**	↔

***Appendix 2* - NHSG Year to date Expenditure and Outturn Variance**





NHS Gloucestershire 2012/13 Integrated Performance Scorecard

Target	Principal Delivery Targets		2011-12 Outturn	Apr 2012	May 2012	Jun 2012 Q1	Jul 2012	Aug 2012	Sept 2012 Q2	Oct 2012	Nov 2012	Dec 2012 Q3	Jan 2013	Feb 2013	Mar 2013 Q4	Year to date	Year end forecast	Perf. Measured
Unscheduled Care																		
Accident & Emergency																		
PHQ23	**4-hour A&E target** - Percentage of A&E attendances where the patient spent 4 hours or less in A&E from arrival to transfer, admission or discharge	Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	C
		GRH	94.5%	94.5%	98.0%	97.6%	95.8%	95.9%	95.9%	94.7%	94.2%					95.8%	> 95%	
		CGH	90.5%	92.1%	97.5%	96.3%	96.8%	98.1%	98.6%	97.3%	96.4%					96.6%	> 95%	C
		GHNHSFT total	92.8%	93.5%	97.8%	97.0%	96.2%	96.9%	97.0%	95.8%	95.1%					96.2%	> 95%	
		GCS - MIU	99.9%	99.9%	99.9%	100.0%	99.9%	100.0%	100.0%	100.0%	99.9%					99.9%	> 95%	C
Ambulance																		
PHQ01	**Cat A 8 min response** - The percentage of Category A incidents, which resulted in an emergency response arriving at the scene of the incident within 8 minutes.	Target	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	
		GWAS	75.6%	76.2%	77.3%	79.7%	77.4%	78.1%	77.5%	76.2%	76.1%					77.3%	> 75%	**C**
		Glos only	76.5%	77.7%	78.6%	79.1%	78.5%	79.5%	80.1%	76.8%	73.7%					77.9%	> 75%	
PHQ02	**Cat A 19 min response** - The percentage of calls resulting in an ambulance arriving at the scene of the incident within 19 minutes.	Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	
		GWAS	95.6%	96.6%	96.4%	96.2%	95.6%	96.1%	95.7%	95.2%	95.4%					95.9%	>95%	**C**
		Glos only	95.5%	95.9%	95.9%	96.0%	95.6%	95.9%	95.0%	95.5%	94.1%					95.5%	>95%	
Planned Care																		
Acute Care Referral to Treatment																		
PHQ19	Percentage of admitted pathways treated with in 18 Weeks	Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	C
		Actual	90.9%	91.4%	91.2%	87.8%	94.0%	94.0%	94.0%	93.3%	94.3%					92.6%	>90%	
PHQ20	Percentage of non - admitted pathways treated within 18 Weeks	Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	C
		Actual	98.3%	97.9%	98.4%	98.3%	98.3%	98.1%	97.8%	97.6%	97.9%					98.1%	>95%	
PHQ19	Percentage of Trauma & Orthopaedic admitted Pathways treated within 18 Weeks	Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	C
		Actual	80.3%	81.3%	80.9%	76.8%	87.0%	88.1%	88.9%	89.1%	92.3%					85.5%	>90%	
PHQ21	Percentage of incomplete Pathways that have waited less than 18 Weeks	Target	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	C
		Actual	94.1%	94.9%	95.3%	94.7%	94.2%	95.5%	95.4%	96.0%	95.8%					95.2%	<92%	
Diagnostics																		
PHQ22	Percentage of patients who have waited more than 6 weeks for one of the 15 key diagnostic tests	Target	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	C
		breaches	1,608	150	361	443	363	366	226	81	20					2,010		
		Performance	2.3%	2.3%	5.4%	6.3%	5.3%	5.3%	3.3%	1.2%	0.3%					3.7%	<1% in Q4	
Cancer Waits																		
PHQ024	Percentage of patients seen within 2 weeks of an urgent referral for suspected cancer	Target	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	C
		breaches	932	150	136	89	103	96	68	82						724		
		Performance	92.2%	85.6%	89.1%	91.0%	90.7%	91.5%	93.1%	93.8%						90.7%	>93%	
PHQ25	Percentage of patients seen within 2 weeks of an urgent referral for breast symptoms where cancer is not initially suspected	Target	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	C
		breaches	165	45	3	0	0	1	2	0						51		
		Performance	88.5%	64.3%	97.8%	100.0%	100.0%	99.1%	97.9%	100.0%						94.2%	>93%	
PHQ06	Percentage of patients receiving first definitive treatment within 31 days of a cancer diagnosis	Target	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	C
		breaches	25	0	2	2	1	0	2	5						12		
		Performance	99.1%	100.0%	99.3%	99.1%	99.6%	100.0%	99.2%	98.3%						99.3%	>96%	
PHQ07	Percentage of patients receiving subsequent treatment for cancer within 31 days where that treatment is surgery	Target	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	C
		breaches	3	0	0	0	1	2	2	0						5		
		Performance	99.4%	100.0%	100.0%	100.0%	98.3%	95.8%	96.0%	100.0%						98.6%	>94%	
PHQ08	Percentage of patients receiving subsequent treatment for cancer within 31 days where that treatment is an Anti-Cancer Drug Regime	Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	C
		breaches	0	0	0	0	0	0	0	0						0		
		Performance	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%							100.0%	>98%	
PHQ09	Percentage of patients receiving subsequent treatment for cancer within 31 days where that treatment is a Radiotherapy Treatment	Target	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	C
		breaches	0%	0%	0%	0%	100%	0%	0%	0%						100%		
		Performance	100.0%	100.0%	100.0%	100.0%	98.9%	100.0%	100.0%	100.0%						99.8%	>94%	
PHQ03	Percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer	Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	C
		breaches	180	16	19	19	18	21	20	28						141		
		Performance	86.0%	84.8%	86.3%	79.6%	82.0%	82.9%	84.0%	81.2%						83.1%	>85%	
PHQ04	Percentage of patients receiving first definitive treatment for cancer within 62 days from an NHS Cancer screening service	Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	C
		breaches	8	1	1	0	1	2	0	1						6		
		Performance	96.9%	95.5%	96.3%	100.0%	95.0%	92.3%	100.0%	96.0%						96.3%	>90%	

Primary and Community Care

Primary care																		
PHQ31_04	Percentage of people eligible for the NHS Health Check programme who have been offered an NHS Health Check	Target	18.0%			5.0%		5.0%		5.0%		5.0%	10.0%	20.0%	C
		Actual	23.6%			5.6%		5.3%					10.9%	>20%	
PHQ31_05	Percentage of people eligible for the NHS Health Check programme that have received an NHS Health Check	Target	6.1%			1.7%		1.7%		1.7%		1.7%	3.4%	6.7%	C
		Actual	9.1%			2.2%		2.1%					4.3%	>6.7%	
Community care																		
Local 2 Week Offers																		
LO1	Average wait to be seen by the Adult Physiotherapy Service	Target (weeks)	2	2	2	2	2	2	2	2	2	2	2	2	2			M
		Ave wait (weeks)	2.6	2.7	2.3	2.7	2.3	2.2	1.7	1.2						1.2		
		Max wait (weeks)	7	11	10	12	9	13								13		
LO2	Average wait to be assessed for a wheelchair by the Specialist and Non-Specialist wheelchair Service	Target (weeks)	2	2	2	2	2	2	2	2	2	2	2	2	2			M
		Ave wait (weeks)	0.9	1.3	0.6	0.5	0.8	0.6	0.8	0.5						0.5		
		Max wait (weeks)	6	7	5	5	7	5								5		
LO3	Average wait to be seen by the Podiatry Service	Target (weeks)	2	2	2	2	2	2	2	2	2	2	2	2	2			M
		Ave wait (weeks)	2.4	2.8	2.5	2.9	3.1	3.5	2.0	1.8						1.8		
		Max wait (weeks)	7	9	12	10	14	14								14		
LO4	Average wait to be seen by the Children's Occupational Therapy Service	Target (weeks)	2	2	2	2	2	2	2	2	2	2	2	2	2			M
		Ave wait (weeks)	1.5	1.2	1.0	1.0	1.2	1.0	1.2	1.3						1.3		
		Max wait (weeks)	3	5	3	3	3	3								3		
LO5	Average wait to be seen by the Children's Physiotherapy Service	Target (weeks)	2	2	2	2	2	2	2	2	2	2	2	2	2			M
		Ave wait (weeks)	1.1	1.3	1.1	1.3	1.4	0.7	0.9	1.1						1.1		
		Max wait (weeks)	6	6	6	6	6	4								4		
LO6	Average wait to be seen by the Children's Speech and Language Therapy Service	Target (weeks)	2	2	2	2	2	2	2	2	2	2	2	2	2			M
		Ave wait (weeks)	1.9	2.0	1.9	1.8	1.8	1.9	1.5	1.9						1.9		
		Max wait (weeks)	9	7	8	6	6	3								3		
Community Care Referral to Treatment																		
Paediatric																		
AMB 01	Percentage of patients referred to the Paediatric Speech and Language Therapy Service who are treated within 8 Weeks	Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	C
		Actual	97.0%	98.0%	99.0%	98.0%	99.0%	100.0%	99.0%	100.0%						99.0%	>95%	
AMB 02	Percentage of patients referred to the Paediatric OccupationalTherapy Service who are treated within 8 Weeks	Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	C
		Actual	97.0%	95.0%	97.0%	96.0%	100.0%	100.0%	96.0%	100.0%						97.7%	>95%	
AMB 03	Percentage of patients referred to the Paediatric Physiotherapy Service who are treated within 8 Weeks	Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	C
		Actual	99.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%						100.0%	>95%	
Adult																		
AMB 04	Percentage of patients referred to the Adult Speech and Language Therapy Service who are treated within 8 Weeks	Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	C
		Actual	96.0%	100.0%	99.0%	97.0%	99.0%	100.0%	99.0%	100.0%						99.1%	>95%	
AMB 05	Percentage of patients referred to the Podiatry Service who are treated within 8 Weeks	Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	C
		Actual	97.0%	98.0%	97.0%	96.0%	96.0%	95.0%	95.0%	97.0%						96.3%	>95%	
AMB 06	Percentage of patients referred to the Adult Occupational Therapy Service who are treated within 8 Weeks	Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	C
		Actual	96.0%	98.0%	96.0%	99.0%	99.0%	100.0%	97.0%	100.0%						98.0%	>95%	
AMB 07	Percentage of patients referred to the Adult Physiotherapy Service who are treated within 8 Weeks	Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	C
		Actual	99.0%	98.0%	95.0%	92.0%	96.0%	97.0%	97.0%	99.0%						95.0%	>95%	
Specialist Nurses																		
AMB 08	Percentage of patients referred to the Parkinson Nursing Service who are treated within 8 Weeks	Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	C
		Actual	99.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%						100.0%	>95%	
AMB 09	Percentage of patients referred to the Diabetic Nursing Service who are treated within 8 Weeks	Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	C
		Actual	100.0%	98.0%	100.0%	100.0%	100.0%	98.0%	96.0%	98.0%						99.0%	>95%	
Public Health																		
PHQ30	Number of clients to the NHS Stop Smoking Service who report that they are not smoking 4 week after setting a quit date	Target	3,950			766		1,506		2,272		3,505	1,506	3,505	C
		Actual	4,003			893		1,769					1,769	>3505	

Mental Health and Learning Disabilities

Adults of Working Age

PHQ12	Proportion of those patients on a Care Programme Approach (CPA) discharged from inpatient care who are followed up within 7 days	Target	95%			95%		95%		95%		95%	95%	95%	C
		Actual	100.0%			100.0%		100.0%					100.0%	>95%	
PHQ11	Number of home treatment packages delivered by Crisis Team	Target	939			255		483		711		939	483	939	C
		Actual	1,844			401		820					820	>939	
PHQ10	The number of new cases of psychosis served by the Early Intervention Team	Target	70			18		36		53		70	36	70	C
		Actual	85			23		46					46	>70	

Improving Access to Psychological Therapies (IAPT)

PHQ13_5	The proportion of people who have depression and/or anxiety disorders who receive psychological therapies	Target	3.9%			2.2%		2.3%		2.5%		2.6%	4.5%	9.6%	C
		Actual	4.8%			1.7%		2.2%					3.8%	>9.6%	
PHQ13_6	The proportion of people who complete therapy who are moving towards recovery	Target	N/A			50.0%		53.8%		53.6%		53.3%	51.9%	52.8%	C
		Actual	50.2%			43.8%		50.7%					47.8%	>52.8%	

Quality

Quality Indicators

PHQ26	Eliminate mixed-sexed accommodation breaches at all providers sites	GHT	393	33	0	0	6	0	0	0	0						39	39	C
		GCS	0	0	0	0	0	0	0	0	0						0	0	C
		2gether	0	0	0	0	0	0	0	0	0						0	0	C
PHQ29	Percentage of all adult inpatients who have had a VTE risk assessment	Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	C
		GHNHSFT	92.9%	94.5%	94.0%	92.9%	93.3%	93.5%	93.9%	93.7%							93.7%	>90%	
		GCS	95.8%	98.1%	97.8%	94.9%	97.9%	96.3%	97.2%	98.3%							97.2%	>90%	

Cleanliness and HCAIs

Methicillin Resistant Staphylococcus Aureus (MRSA)

PHQ27	Number of MRSA infections (Health Community)	Glos HC target	14	1	1	1	1	0	0	0	0	0	0	0	0	4	4	C
		Glos HC actual	10	0	2	0	2	1	1	0	1					7	>6	
PHQ27	Number of post 48 hours MRSA infections post 48 hours (Acute Trust)	GHNHSFT target	5	1	0	0	0	0	0	0	0	0	0	0	0	1	1	C
		GHNHSFT actual	3	0	0	0	0	1	0	0	1					2	1	

Clostridium Difficile (C.Diff)

PHQ28	Number of total C Diff infections (Health Community)	Glos HC target	182	19	16	13	16	13	11	11	11	11	22	20	19	110	182	C
		Acute Hosp	97	6	4	5	10	13	2	4	4					48		
		Comm Hosp	24	1	2	1	2	2	0	2	0					10		
		Community	158	11	10	13	12	14	7	15	10					92		
		Glos HC actual	279	18	16	19	24	29	9	21	14					150	>182	
PHQ28	Number of post 48 hour C Diff infections (Acute Trust)	GHNHSFT target	73	9	8	5	5	5	5	5	6	6	6	6	7	48	73	C
		GHNHSFT actual	92	6	6	6	8	10	1	6	4					47	73	

Notes

PHQ 2012/13 NHS Operating Framework commitments
EC Existing commitment
AMB Strategic Health authourity Ambition objective
Local Local target
LO Local offer to Gloucestershire Health Community to reduce waiting times

Key to RAG status

Green On or above plan
Amber Below plan
Red Significantly below plan

Key to 'performance measured'

C = assessed on cumulative performance against plan
M = Figure as at end of month

Key to abbreviations

GNHSFT - Gloucestershire Hospitals NHSFT
GCS - Gloucestershire Care Services
GWAS - Great Western Ambulance Service

Appendix 4 - NHSG Capital Programme 2012/13

Month 8 (November 2012)

Capital Programme 2012/13	Year to date £'000	2012/13 Budget £'000	Forecast Outturn £'000	Variance £'000
Community Hospitals Central Funding	1,962	11,146	11,146	0
Operation Capital	3,998	8,028	8,028	0
Other Allocations	0	0	0	0
Additional capital sources	0	0	0	0
Receipts from Sales	0	7,550	6,034	(1,516)
Forecast capital resources	**5,960**	**26,724**	**25,208**	**(1,516)**
Capital Applications				
North Cotswolds and George Moore Clinic	676	1,000	1,000	0
Estate improvements	438	6,753	4,694	2,059
Newent Health centre	154	200	250	(50)
Capital grants	2,600	5,069	3,869	1,200
Tewkesbury Hospital	1,962	11,746	11,746	0
Berkeley Court	0	0	0	0
Other schemes	130	0	130	(130)
Total capital applications	**5,960**	**24,768**	**21,689**	**3,079**
Resources less applications	**0**	**1,956**	**3,519**	**1,563**

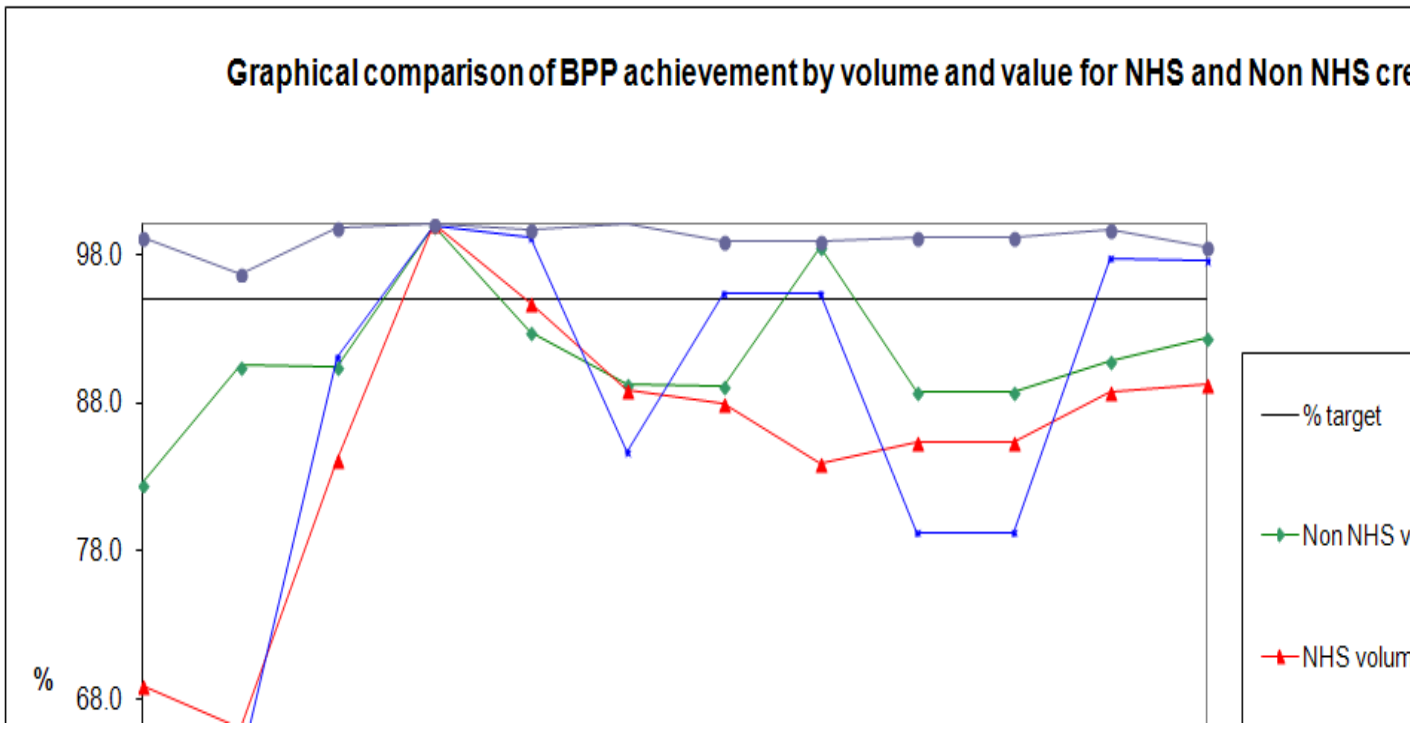
Appendix 5 - **NHSG Better Payment Practice Code**

Better Payment Practice November

	Against 30 days				Against 10 day		
	Performance vs. 30 day BPP				Performance vs. 10 d		
Non NHS	Month		Year To Date		Month		Ye
	Nos.	£'m	Nos.	£'m	Nos.	£'m	N
Total Bills paid	4,445	9.11	36,875	87.81	4,445	9.11	36,
Total Bills paid within target	4,108	8.89	33,283	82.24	2,386	4.04	16,
%age of bills paid within target	**92%**	**98%**	**90%**	**94%**	**54%**	**44%**	**4**

NHS	Month		Year To Date		Month		Ye
	Nos.	£'m	Nos.	£'m	Nos.	£'m	N
Total Bills paid	318	47.96	3,155	366.03	318	47.96	3,
Total Bills paid within target	284	47.24	2,788	364.33	130	42.44	1,
%age of bills paid within target	**89%**	**98%**	**88%**	**99%**	**41%**	**88%**	**3**

ALL	Month		Year To Date		Month		Ye
	Nos.	£'m	Nos.	£'m	Nos.	£'m	N
Total Bills paid	4,763	57.08	40,030	453.84	4,763	57.08	40,
Total Bills paid within target	4,392	56.13	36,071	446.57	2,516	46.48	18,
%age of bills paid within target	**92%**	**98%**	**90%**	**98%**	**53%**	**81%**	**4**



***Appendix 6* - NHSG Cash Reconciliation**

Cash Performance Indicators

Month: September Month 7

Cash Limit	**£'000**
Total Annual Cash Limit - anticipated	944,874
Cash Drawn down to date	472,000
Prescribing cash	44,911
Dental Services cash	10,849
Pharmacy cash	11,197
Total charge to cash limit	538,957
% of cash drawn down to total annual cash limit	57.0%

Month end balance in bank account (£'000)	**(1,044)**
Month end balance as % of cash limit	-0.1%

Cash Reconciliation

	£'000
Cash drawn down to date	538,957
Less closing bank balance	1,044
Cash utilised	540,001
% of adjusted cash utilised to total annual cash limit	57.2%
7 months pro-rata of cash limit	58.3%

NHS
Gloucestershire
Swindon

Appendix 7 - NHS Gloucestershire Balance Sheet

Statement of Financial Position as at 30th November 2012

Description	As at 30th Nov 2012 £'000	As at 31st March 2012 £'000
NON CURRENT ASSETS		
Property, Plant & Equipment	94,474	93,937
Intangible Assets	130	157
TOTAL NON CURRENT ASSETS	**94,604**	**94,094**
CURRENT ASSETS:		
Inventories		-
Trade & Other Receivables	14,796	16,342
Cash & Cash Equivalents	5,719	183
SUB TOTAL CURRENT ASSETS	**20,515**	**16,525**
Non Current Assets Held for Sale	5,590	5,590
TOTAL CURRENT ASSETS	**26,105**	**22,115**
CURRENT LIABILITIES		
Trade & Other Payables	(57,787)	(49,905)
Provisions	(476)	(1,109)
TOTAL CURRENT LIABILITIES	**(58,263)**	**(51,014)**
NET CURRENT ASSETS/(LIABILITIES)	**(32,158)**	**(28,899)**
TOTAL ASSETS LESS CURRENT LIABILITIES	**62,446**	**65,195**
NON CURRENT LIABILITIES		
Trade & Other Payables	(205)	(205)
Provisions	(2,051)	(2,051)
Borrowings		
TOTAL NON CURRENT LIABILITIES	**(2,256)**	**(2,256)**
TOTAL ASSETS EMPLOYED	**60,190**	**62,939**
FINANCED BY TAXPAYERS EQUITY:		
General Fund / I & E Reserve	48,106	50,855
Revaluation Reserve	12,289	12,289
Local Government Pension Scheme Reserve	(205)	(205)
TOTAL TAXPAYERS EQUITY	**60,190**	**62,939**

Agenda Item 9

Gloucestershire Clinical Commissioning Group (Shadow Board)

Meeting Date	**Thursday 17th January 2013**
Title	**QIPP Programme Update**
Executive Summary	This paper provides the GCCG with an update of progress against the QIPP themes and main programmes of work, identifying progress to date, key risks and proposed remedial actions.
Key Issues	• NHSG has planned to deliver a surplus of £8.9m for the year 2012/13.
Risk Issues: **Original Risk** **Residual Risk**	**Risk:** Non delivery of saving and service redesign plans. **Addressed by:** Close working with the Project Management Office. Identification of additional saving schemes and slippage within other service area budgets. **Current rating:** 15 **Risk:** QIPP programme benefits realisation shifts. **Addressed By**: Project management and performance data utilised to predict benefits realisation, reduce level of risk within assumption. Work programmes continue to drive harder on savings delivery in year. **Current Rating**: 8
Financial Impact	Not meeting key financial targets
Legal Issues(including NHS Constitution)	Not applicable.
Impact on Equality	Not applicable.

and Diversity	
Impact on Health Inequalities	Not applicable.
Impact on Sustainable Development	No sustainable development issues are highlighted by the report.
Patient and Public Involvement	Not applicable.
Recommendation	The GCCG are asked to: • Take note of the performance against planned QIPP programme and the proposed remedial actions.
Author	Kelly Matthews
Designation	PMO Lead
Sponsoring Director (if not author)	Mary Hutton

Agenda Item 9

Gloucestershire Clinical Commissioning Group
(Shadow Board)

Thursday 17th January 2013

QIPP Programme Update

1 Introduction

1.1 NHS Gloucestershire has a requirement to del iver £29.8m recurrently from its QIPP programme, to ensure financial stability moving in to 2012/13. NHS Gloucestershire are currentl y developing QIPP plans to s upport the planned delivery of a surplus £8.9m in 2012-13. To achieve thi s position commissioner QIPP schemes are being deli vered in conjunction with local providers to ensure whole system reform. To support this change NHSG has identified a source of invest to save funding and maintains uncommitted headroom to pump prime service change.

This paper and supporting appendices sets out the key progress to date, key risks and proposed remedi al actions and provides an overvi ew of the 2012/13 QIPP programme currently being developed.

2 QIPP Programme Overview

2.1 QIPP Themes

The QIPP programme covers the br eadth of the commissioni ng agenda and all themes are underpinned by a core principle of care closer to home, in line with the organisational strategy.

The rolling QIPP programm e has been spli t into the following themes and programmes.

QIPP Theme	Programme
Unscheduled Care & Long Term Conditions (Including Community Care)	• System wide change • Pathway Development (Assessment, Diagnostics and Ambulatory Care) • Self-Care Management and Prevention.

	• Community Provision
Planned Care	• Contract Strategy • Service Strategy (including use of clinical programme approach) • Demand Management
Reducing variability in Primary Care	• General Medical Services • Optometry • Dental
Prescribing	• Best Practice • Waste Medication • Medicine Optimisation • GP Dispensing • Joint Formulary
Mental Health and Learning Disabilities Services	• Improve services for clients with challenging behaviour • Improving Health Inequalities • OOC Placements • Eating Disorders • Access to Psychological Therapies
Continuing Healthcare	• EoL Domiciliary Care Procurement • Testing Eligibility • Reducing Referrals
Non Clinical	• Estates • Back Office

The supporting appendices provide a detailed overview of the programme and individual projects.

3 Finance

Savings Plan 2012/13

Against a requirement to deliver £29.8m worth of savings in 2012/13, across the QIPP programme plans are in place to deliver £30.5m of cashable savings, as shown in table below.

(Note: all figures are shown in £000's in all tables)

Theme	Target Savings	Planned Savings (Rec)	Planned Savings (Non Rec)	Grand Total	Savings Gap (In Cash Terms)
Unscheduled Care / Long Term Conditions	£5,043	£4,252	£791	£5,043	£0
Planned Care	£5,691	£5,547	£50	£5,597	-£94
Prescribing	£7,526	£7,526	£0	£7,526	£0
Primary Care	£1,500	£0	£1,500	£1,500	£0
Community Care	£3,000	£3,109	£0	£3,109	£109
Mental Health	£1,200	£850	£0	£850	-£350
Learning Disabilities	£2,500	£2,500	£0	£2,500	£0
Continuing Health Care	£2,200	£2,200	£0	£2,200	£0
Non Clinical	£1,150	£0	£650	£650	-£500
Contract Contributions	£0	£1,523	£0	£1,523	£1,523
Grand Total	**£29,810**	**£27,507**	**£2,991**	**£30,498**	**£688**

The over planning of savings allows for risk mitigation in relation to shifts in the potential realisation. Alongside the savings shown above further benefits in relation to avoiding growth equates to an additional £1.8m of benefit.

Based on the application of assumed timescales for delivery of individual QIPP schemes, the table below demonstrates expected phasing of savings delivery by quarter throughout 2012/13.

Theme	Q1	Q2	Q3	Q4
Unscheduled Care / Long Term Conditions £556		£1,449	£1,589	£1,448
Planned Care	£220	£1,382	£1,973	£2,023
Prescribing £4,132		£1,132	£1,132	£1,132
Primary Care	£0	£0	£750	£750
Community Care	£750	£786	£786	£786
Mental Health	£0	£0	£175	£675
Learning Disabilities	£0	£833	£833	£833
Continuing Health Care £1,750		£150	£150	£150
Non Clinical	£0	£0	£0	£650
Contract Contributions £381		£381	£381	£381
Grand Total	**£7,788**	**£6,113**	**£7,769**	**£8,828**
	26%	*20%*	*25%*	*29%*

Savings Position as at end October 2012.

At month 7 the projected savings deliv ery within 2012/13 is on target for £29.8m, of which £24.9m relates to recur rent savings, as shown in the table below.

Theme	Target Savings (£000's)	FOT Recurrent Savings (£000's)	FOT Non Recurrent Savings (£000's)	Month 7 Grand Total (£000's)	Variance (£000's)
Unscheduled Care/Long Term Conditions	£5,043	£1,344	£0	£1,344	(£3,699)
Planned Care	£5,691	£4,310	£0	£4,310	(£1,381)
Prescribing £7,526		£7,026	£0	£7,026	(£500)
Primary Care	£1,500	£250	£1,095	£1,345	(£155)
Community Care	£3,000	£3,000	£0	£3,000	£0
Mental Health	£1,200	£385	£0	£385	(£815)
Learning Disabilities	£2,500	£2,300 £0		£2,300	(£200)
Continuing Health Care	£2,200	£3,031	£0	£3,031	£831
Non-Clinical (Exclu. Management Costs*)	£1,150	£0	£0	£0	(£1,150)
Contingent Resources	£0	£1,800	£3,746	£5,546	£5,546
GHFT Risk Share	£0 £1,523		£0	£1,523	£1,523
Grand Total	**£29,810**	**£24,969**	**£4,841**	**£29,810**	**£0**

Although the proj ected savings deli very is on target, £3.7m is allocated to non-recurrent conti ngent resources. The mitigating actions to address the use of contingent resources on a recurrent basis can be noted as:

1) Continue to increase the planned savings position to over plan beyond requirement; building in contingency for slippage in scheme delivery.
2) Review of in year delivery to assess if the benefits realisation from existing projects can be increased.
3) There is a focus on understandi ng the increased unschedul ed care acute admissions; to ensure QIPP programmes are in place to effectively impact upon the increased spend and ensure servi ces are developed to care for people at right time, in right place.
4) The Your Health, Your Care strateg ic implementation plan is modelling the impact from the pri ority areas for change, including key components of the QIPP programme, over the next 5 years to ensure recurrent change into 2013/14 and beyond.

4 Current Key Risks and Proposed Remedial Actions

The key risks from across the QIPP programme can be noted within the table below, alongside their remedial actions.

Key Risks	(L) (1-5)	(C) (1-5)	Total	Remedial Actions
Insufficient plans for reassurance regarding financial stability moving into 2013/14.	3	5	15	Director and clinical leadership at theme level, further projects in development for additional saving. Contingency and non-recurrent slippage identified to support delivery of control total. Further ideas under development.
Insufficient engagement across the health community with regards to savings plans.	2	4	8	Theme directors responsible for ensuring contractual engagement, QIPP health community groups in place to ensure senior clinical, management and financial sign up. Joint approach to inclusion in contracts for 2012/13. Alignment to Gloucestershire Strategy for Care.
Insufficient detail to map impact in relation to workforce and provider capacity.	3	4	12	Business case process requires that all projects are fully scoped for service outcomes including workforce and bed impact. Routine performance management of both business case preparation and project implementation ensures consistent and targeted focus on these areas. The Resources Steering Group routinely review system workforce and capacity impacts as part of the strategic review for the health community operating framework and plan.

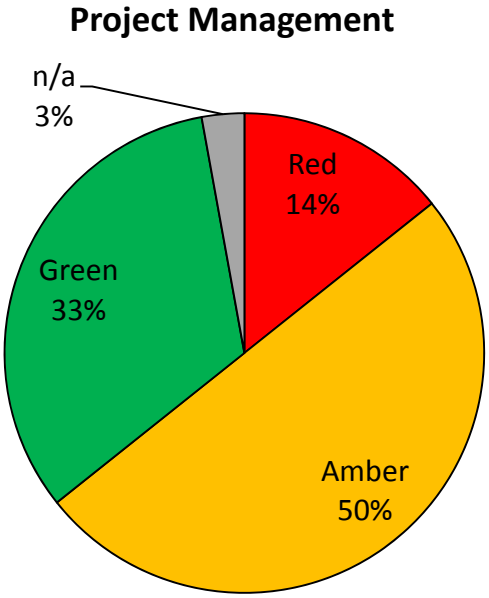
5. QIPP Programme Updates

A robust programme management process has been developed to ensure governance mechanisms are in place to performance manage delivery.

Programmes and projects are assessed in relation to the following 2 perspectives:

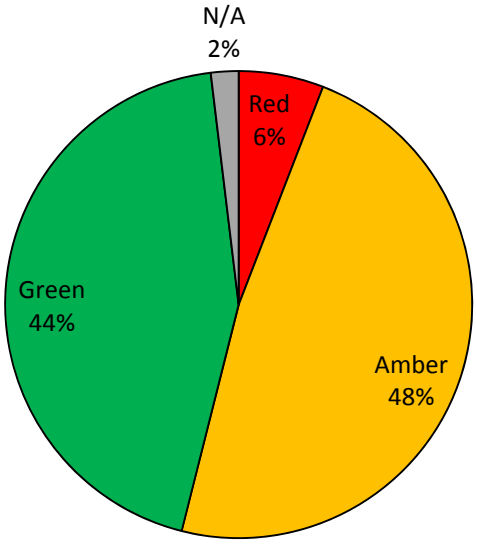
- Project Management. Robustness of project plan and ability to deliver against key milestones for implementation.
- Benefits realisation. Ability to deliver financial outcome as proposed within the original project plan assumptions.

Currently there are 71 QIPP projects included within the programme, assigned as Raised, Open (Implementation) and Open (Performance Management) of which the % assessed as red, amber of green rating for project management are shown in the chart below.



Since the previous report the projects RAG assessments have maintained position.

Benefits Realisation (by value £)



Since the previous report the projects assessed as green have increased to 45% (from 44%), amber risk rating has decreased to 46% (from 48%) and a subsequent slight decrease increase red schemes to 7% (from 6%).

The current highlight programme report is attached within appendix A, detailing:

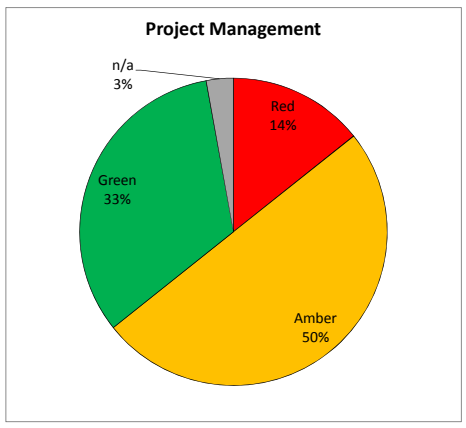
- Key Achievements
- Red or significant amber risk programme areas and mitigating actions.

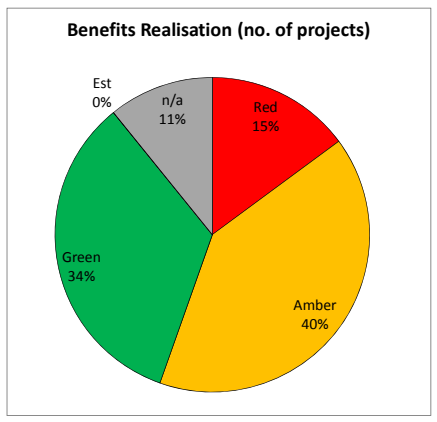
5 Supporting Documents

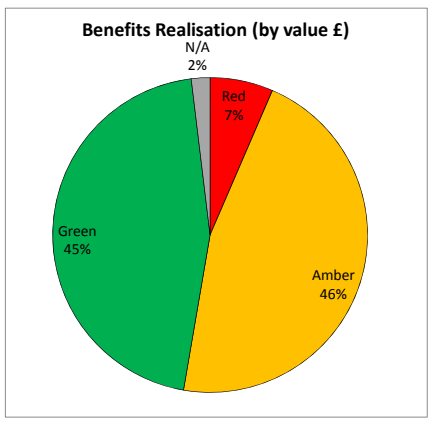
Appendix 1: QIPP Highlight Performance Report (December 2012)

Programme Management Office

QIPP Highlight Performance Report December 2012
Overview







Key		
Project Status:	**Green**	Project documentation well developed programme of work on track.
	Amber	Further work required within project documentation, some slippage in milestones.
	Red	Limited project documentation completed or project implementation delayed.
Benefits Realisation:	**Green**	KPIs on track, high level of confidence in ability to deliver outcome, contract mechanisms are in place.
	Amber	The scheme is on track but concerns around benefits to be realised.
	Red	Limited or no confidence in delivery of outcome.

Red Programme	**Reasons and Actions**
Planned Care	(Red rating based on both project management and benefits realisation assessment, dependent on size, priority and complexity of workstream)
Community IV Service (Planned Procedures)	Operational pathway issues still occuring and therefore less activity in the community service than expected. Case mix and delivery model being reviewed by Gloucestershire Care Services and NHS Gloucestershire jointly to agree a plan into 2013-14.
Significant Amber Risks	
Telehealth (LTC Theme)	As at 1st January 2012, 787 patients have been referred to telehealth within the county - the deployment of units across Gloucestershire remains challenging. A robust communication and engagement plan is in place and will be need to be further developed throughout 2012-13 in order to reach 2000 unit deployment trajectory. Additional resource has been agreed to support clinical engagement. GCS are on track with recommendations for referral target, although there are challenges with conversion rates.
T&O Programme	NHSG are committed to developing a joint programme with GHNHSFT to deliver agreed financial impact alongside alignment to the savings and 18wk RTT target. Generic MSK pathway mapping and specific pathway mapping for spinal pathways have been developed and considered by the CPG. The CPG & CCG have also supported the development of a trial programme, for 2013/14 ahead of procurement to commission an integrated service model in future years.
Enhanced Community Provision	The Enhanced Community Provision Programme equates to £2.4m of the USC programme in 2012-13, with a two thirds risk share to NHSG. Projects within the programme include Living Well and Use Of Community Hospital Beds. The overall delivery of this programme is amber reflecting the USC activity position to date,
OPAL	The commissioner service specification has been developed and shared with GHNHSFT; inclusive of feedback from CCG. Issues identified by the provider are yet to be resolved with regard to risk share of the financial savings and investments. Until these are agreed service implementation will not be able to progress any further.
Respiratory	Noted increase in emergency admissions. Trial scheme for the Oxygen Assessment Service noted reviews completed for all approx. 400 identified users of Home Oxygen. Oxygen Assessment Service business case still under development for the implementation of a permanent oxygen assessment and review service.

	Significant Progress to Date
GP Peer Review	GP Peer Review (3 specialty min.) went live countywide in November 2011, with all practices in the county signed up to a form of peer review (in house design or NHSG QoF QP Scheme). Performance data from Nov -11 to November - 12 indicates a 5% reduction in GP referrals for those specialties selected. The 12-13 scheme will aim to expand to all practices peer reviewing all specialty referrals by September 2012 - currently 86% of practices have signed up to the LES scheme.
Advice & Guidance	Advice and Guidance commenced with Dermatology in June 2012. Initial uptake and feed back has been positive in both primary and secondary care. As at November 2012 187 referrals for Dermatology Advice & Guidance had been received, 58% were returned to primary care and 41% onwardly referred to secondary care. A&G for Renal went live in November 2012. The joint working group (NHSG & GHNHSFT) have idenitifed Haematology and Endocrinology as the next specialties to go live.
Risk Stratification	NHS Gloucestershire CCG have endorsed procurement of risk stratification tool to support development of integrated community teams
CHC	In terms of benefits realisation this QIPP Programme is forecast to over deliver against the initial target set.
Prescribing	Prescribing growth rate currently -1.64%, 5th best in South West region.

Agenda Item 10

Gloucestershire Clinical Commissioning Group (Shadow Board)

Meeting Date	**17th January 2013**
Title	**Annual Operating Plan: 2013/14**
Executive Summary	This paper provides an overview of the process to develop the Clinical Commissioning Group (CCG) Annual Operating Plan for 2013/14. This is in the context of the nati onal guidance 'Everyone Counts: Planning for patients 2013/14' published by the NHS Commissioning Board.
Key Issues	The plan will identify the following key areas • Key elements of transformational change • Key risks to del ivery for the CCG in 2013/14 • Overview of national targets to be delivered • Financial plan
Risk Issues: **Original Risk** **Residual Risk**	Completing the plan by 31st March 2013 **Risk: 2x3: 6** **Addressed by:** Timetable in place, building on exi sting strategy. Internal management process in place to hold leads to account **Current rating: 2x3 : 6**
Financial Impact	This will be worked through as part of the development of the plan
Legal Issues(including NHS Constitution)	The Annual Operating Plan will define how the CCG will meet its legal commitments contained within the NHS Constitution and other national guidance
Impact on Equality and Diversity	The finalised plan will include an assessment on equality and diversity
Impact on Health Inequalities	The finalised plan will include an overview of any impacts on health inequalities

Impact on Sustainable Development	The finalised plan will include any detail on sustainable development impact
Patient and Public Involvement	Elements of the plan will be based on the 'Your Health Your Care' strategy which was subject to public engagement.
Recommendation	The Board are asked to note the planning process for the development of the Annual Operating Plan.
Author	Nicki Millin
Designation	Deputy Director
Sponsoring Director (if not author)	Mark Walkingshaw

Agenda Item 10

Gloucestershire Clinical Commissioning Group
(Shadow Board)

17th January 2013
Annual Operating Plan: 2013/14

1.0 Introduction

There is a national requirement for the Clinical Commissioning Group to produce an Annual Operating Plan (AOP) for 2013/14, which outlines its key programmes of work, how national standards will be met and the financial impact of plans. This is in the context of the national guidance 'Everyone Counts: Planning for patients 2013/14' published by the NHS Commissioning Board.

The following is a summary of how the CCG intends to develop its plan, which it will need to submit to the NHS Commissioning Board Local Area Team (LAT) for assessment. The first draft will be submitted to the LAT on 25th January 2013 with the final plan agreed by 31st March 2013. The AOP will be presented to the February meeting of the Board for review and discussion prior to final sign off 31st March 2013.

2.0 Outline of Planning Process

Plan sections	Status	Actions
Key elements of transformational change	The 'Your Health Your Care' strategy identifies the key areas of change for the CCG in conjunction with its partners for the next five years. The Strategic Implementation Plan (SIP) identifies the key areas for delivery within year 1, and these feed into the CCG QIPP plan by provider for 2013/14.	First draft Commissioning Intentions shared with providers, final version to be issued by 31st January 2013. QIPP plans will be finalised at provider level by 28th February 2013
Key Risks: YHYC and	Risk assessment of YHYC SIP in place	To be refreshed

assessment of performance	Assessment of performance against key targets reported on a monthly basis.	Refreshed monthly, risk scores for 2013/14 to be produced by 17th January 2013
Confirmation national targets will be met	All national targets and NHS Constitution targets are identified to be met by the end of 2012/13.	Challenging area for 2013/14 Health Care Acquired Infection targets
Identify 3 local quality priorities against which the CCG needs to make progress during 2013/14	Initial assessment of Gloucestershire areas of development linked to the Health and Wellbeing Strategy, to be triangulated with published CCG benchmarked data.	CCG development session to review the information and propose 3 local priority areas to be confirmed by Health and Well Being Board
Activity Plans	Activity plans need to be developed which identify volumes of activity required to ensure that the CCG has sufficient capacity commissioned to meet the needs of the population.	Modelling work based on historical trends is taking place and will be produced as first draft by 25th January and refreshed March 2013
Financial Information	This is based on the Medium Term Financial Plan, which is being refreshed following the publication of CCG allocations	To be completed 25th January 2013

3.0 Recommendations

The CCG are asked to note the pla nning process in place to develop the Annual Operating Plan for 2013/14.

The plan will be presented to the February meeting of the Board for review and discussion prior to final sign off 31st March 2013.